IMPROVING WOMEN'S HEALTH: UNDERSTANDING DEPRESSION AFTER PREGNANCY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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IMPROVING WOMEN'S HEALTH: UNDERSTANDING DEPRESSION AFTER PREGNANCY

WEDNESDAY, SEPTEMBER 29, 2004

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:09 p.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Pickering, Pitts, Barton (ex officio), Brown, Towns, Green, DeGette, Capps, and Rush.

Staff present: Cheryl Jaeger, majority professional staff; Chuck Clapton, majority counsel; Eugenia Edwards, majority legislative clerk; and John Ford, minority counsel.

Mr. BILIRAKIS. Good afternoon, the hearing will come to order. Today's hearing, "Improving Women's Health: Understanding Depression After Pregnancy," addresses depression in women, an important issue that is often overlooked.

Depression is a disease that many people feel uncomfortable discussing. It is often dismissed because there is a thought that this condition is personal weakness, or you should just be able to snap out of it. However, this is a potentially serious and debilitating condition for those who experience depression. Depression affects your body, your mood and your thoughts. It is different from being in a bad mood.

Without treatment, a depressed individual can suffer from symptoms such as hopelessness, fatigue, lack of appetite, and thoughts of suicide, to name a few. It can last weeks, months or years.

Appropriate treatment, however, can help most people who suffer from depression.

It's extremely disconcerting that women experience depression about twice as often as men. While we don't know all of the causes of depression, we do know that hormonal factors may contribute to the increased rate of depression in women, and many women are also particularly vulnerable after a pregnancy.

In today's hearing, we will discuss two aspects of depression in women, postpartum depression and post-abortion depression. These are sensitive matters in an area where we really don't have a lot of conclusive answers, and that's why I'm interested in hearing from our witnesses and learning more today. While each member has his or her own views on some of the issues that we'll be dis-

cussing today, none of us is an expert in the field of depression. So, I believe we will really be able to learn from today's hearing.

I'd like to thank our witnesses for being here today, especially Carol Blocker and Michaelene Fredenburg, who will share their personal experiences with us today. Ms. Blocker lost her daughter who suffered from postpartum depression. Ms. Blocker, I'm so sorry for your loss. No parent should have to go through what you experienced with the loss of your dear daughter, Melanie. Ms. Fredenburg, being willing to share your personal experience with abortion is extremely brave, and I'm so glad to have you here today.

I'd also like to thank, of course, our other two witnesses today, Doctor Nada Stotland with the American Psychiatric Association, and Doctor Elizabeth Shadigian, with the Department of Obstetrics and Gynecology at Mott Hospital. I look forward, as we all do, to hearing from you.

Again, thank you for being here today, and I'm pleased to yield to the ranking member of the subcommittee, my friend, the gentleman from Ohio, Mr. Brown, for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman, and thanks to our witnesses for joining us this morning. Ms. Blocker, thank you for your courage and your willingness to share your story with us.

Postpartum depression is a clinically proven, alarmingly prevalent women's health condition. Postpartum depression is a mental health threat that affects, we believe, at least 10 percent of new mothers, 400,000 women, every year. It causes tremendous suffering, and in its most severe form it can jeopardize the lives of new mothers, as well as their children.

It affects women without regard to race, or age, or socioeconomic status. It affects new mothers and women with more than one child equally, and no one knows for sure what causes this debilitating condition.

Despite that, important innovations are being made in understanding and treating postpartum depression. It's appropriate and vitally important for this subcommittee to learn more about this condition. Unfortunately, my Republican colleagues chose to politicize today's hearing.

I'm sorry that one of our witnesses has dealt with depression that she attributes to the circumstances surrounding her abortion. I'm not surprised, though, that the majority chose to introduce the topic of abortion in this debate. Had the majority truly been interested in expanding the focus of this hearing to look at the mental health of women who have been pregnant, then where are the witnesses who have experienced miscarriage, or stillbirth, or adoption for that matter? Where is the witness who is currently facing an unintended pregnancy who didn't know about birth control because her high school couldn't get funding for comprehensive sex education?

Anti-choice Members of Congress have every right to promote their agenda, but it's a shame they chose to turn this important public health hearing into yet another attack on the reproductive rights of women. This hearing should promote the well-being of women, not compromise it. Postpartum depression is a serious

mental health threat. Its impact on women and families is enormous. We should keep our eye on the ball.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. We try to do some good in terms of learning up here, and it always seems to always turn negative.

Mr. Pitts—well, Mr. Chairman, I'm sure you would like to make an opening statement. Proceed.

Chairman BARTON. Thank you, Chairman Bilirakis, for holding this hearing, and before I read my prepared statement, let me say that the reason that we are doing this hearing is twofold. Former Congressman Tauzin, the chairman of this committee, had promised Mr. Rush that we would do a hearing, and Mr. Tauzin had also promised Mr. Pitts that we would do a hearing. And when I became Chairman, both of those gentlemen told me that they had that promise and I kept it, and that's why we are having the hearing today.

We have two panels, because they are, while they are similar issues they are separate, and we wanted to have each panel, basically, Mr. Rush's panel first, and then Mr. Pitts' panel, and I felt that it was acceptable to do that. There's nothing at all where we are trying to be partisan, just the opposite, we are trying to be fair and get two issues that are important, dissimilar in some ways, similar in some ways, on the table for the American people. But, if there is angst and frustration to be expressed, it should be expressed at me, because I'm the one who honored the commitment that the former Chairman had to both the distinguished members of this committee, and I think that we should keep our promises even when we are not the individual who made the initial promise, and that's why we are doing it.

I do want to thank you two women for being here, and our second panel also. This is a serious issue. Depression is very serious. We've got a series of hearings going on right now in the Oversight Subcommittee where we are looking at antidepressant drugs that are being prescribed to children. One out of every six U.S. children is on some sort of an antidepressant. For women who have given birth, postpartum depression is a real illness, there's no question about that.

Research that's been conducted, with the support of the National Institutes of Health, has uncovered a variety of issues about this particular subject that's going to be important in this hearing. We know that for women the risk of depression increases after puberty, indicating possible hormonal links. We also know that new imaging tools have helped researchers better understand how the brain works, enabling them to highlight brain functions with respect to depression in women.

The mapping of the human genome has allowed for the first time scientists to identify and explore potential genetic triggers. This is all basic information, we combine it, hopefully, in a way that can lead to an improved targeted treatment for depression. The more information we collect and analyze, the better off we'll be.

So I'm happy to have this hearing, Mr. Chairman, and I look forward to it, and I'm going to stay for as much of it as possible, and hopefully have a chance to ask some questions.

[The prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Mr. Bilirakis, for holding this hearing today.

There is one thing that everyone in this room should agree on: depression is a serious illness that we need to better understand. Statistics tell us that women are roughly twice as likely to develop depression than men. That's powerful information. With this fact, scientists can target their research efforts in areas that are unique to women, like reproductive, hormonal, genetic, and other biological factors.

Research conducted with the support of the National Institutes of Health has uncovered a variety of useful information. We know that for females, the risk of depression increases after puberty, indicating possible hormonal links. New imaging tools are helping researchers to better understand how the brain works, enabling them to highlight brain functions with respect to depression. The mapping of the human genome allows, for the first time, scientists to identify and explore potential genetic triggers. All of this basic information combined together will ultimately lead the way to improved, targeted treatments for depression. The more information we collect and analyze, the better off we will be.

I am concerned that some have suggested that it's unnecessary to even evaluate the impact of abortion and its relationship to depression. We need to know more information about depression, not less. Right now, scientists are still evaluating the impact of depression screening and intervention tools to improve health outcomes. When there are still outstanding questions about the incidence and prevalence of perinatal depression, it's obvious to me that we still need to learn a lot more.

Patients look to their doctors to provide them with the latest information about treatments and options. This is the case in every medical situation: whether it is a wife seeking advice about pregnancy or a young woman contemplating an abortion. Medical procedures are risky. They often have permanent consequences. I want the patient to be able to make a truly informed decision.

I would like to thank all of the witnesses for taking the time to participate in this hearing today. I look forward to the testimony.

Mr. BILIRAKIS. The Chair thanks the chairman.

Mr. Rush is recognized for 3 minutes for an opening statement.

Mr. RUSH. I want to thank you, Mr. Chairman, for recognizing me, and I certainly want to thank the chairman of the full committee for keeping his promise, or keeping the promise of the former chairman. I want to thank him for all that he has done on behalf of the suffering—women who suffer from postpartum psychosis, disease and depression.

I want to certainly welcome two constituents of mine who are at the panel. First of all, I want to welcome my friend for many years, Ms. Carol Blocker, who is the mother of Melanie Stokes Blocker. She is a person who we are quite proud of in my city and my district, and she's someone who has remarkable courage and strength in that her tragic and heartbreaking tragedy that happened to Melanie Stokes Blocker is—Melanie Blocker Stokes—she's taken that and she's really become quite a fighter on behalf of countless other women who suffer from postpartum psychosis, and postpartum depression, and postpartum diseases, mental diseases.

And I want to also thank Doctor Stotland, who is renowned in this field of mental health. She is a former—she is a professor, practicing psychiatrist and a professor right now in Chicago, renowned in her capacity, and also in her public works, published works rather, in this particular area, and I certainly welcome her testimony.

I want you to, Mr. Chairman, to understand, as I know you do, that postpartum depression is a very real mental illness that affects and afflicts millions of women nationwide. and what we used

to naively and thoughtlessly refer to as the "baby blues" is a real psychological phenomenon that can lead to severely destructive behavior on the part of the mother.

Ever since my constituent, the late Melanie Blocker Stokes, committed suicide after the birth of her child due to postpartum psychosis, I have become a passionate advocate for the aggressive treatment of this disease. Because of my commitment to eradicate this disease, in each of the last 3 years I have introduced H.R. 846, the Melanie Blocker Stokes Postpartum Depression Research and Care Act. Given the severity of this issue, Mr. Chairman, I would like to thank you again and Chairman Barton for holding this important hearing.

It is my opinion that while both issues are important, Mr. Chairman——

Mr. BILIRAKIS. Please finish up.

Mr. RUSH. [continuing] Mr. Chairman, I ask for unanimous consent that I be granted a minute of Mr. Towns time.

Mr. BILIRAKIS. I've heard them all, but I'm not sure I've heard that one.

Mr. RUSH. Yes, well you heard it——

Mr. BILIRAKIS. Without objection, you have an extra minute.

Mr. RUSH. All right.

Mr. Chairman, as you know, nearly 80 percent of new mothers experience the baby blues, and over 400,000 women suffer from postpartum mood changes. And, Mr. Chairman, my bill, in a nutshell, my bill is aimed at addressing this severe problem, this extreme problem, and my bill, Mr. Chairman, is meant to expand and intensify the research at the National Institutes of Health, the National Institutes of Mental Health, and, Mr. Chairman, I look forward to this hearing, I look forward to the views of the panelists, and, Mr. Chairman, I look forward to congressional action on support and passage of the bill that exists in this subcommittee.

Thank you, and I yield back.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Pitts is recognized for 3 minutes.

Mr. PITTS. Thank you, Mr. Chairman, and thank you for holding this hearing today.

As you know, we talked a long time ago about the importance of this issue, and I'm glad to see the hearing finally come to fruition, and I appreciate the Chairman keeping the commitments made previously.

I'm going to keep my comments short, focus them on the post-abortion depression, since that is what my bill, H.R. 4543, the Post-Abortion Depression Research and Care Act, addresses. However, this statement should not be construed as opposition to the other topic being discussed today.

Mr. Chairman, women have a right to know about the long-term effects of abortion on their mental and emotional well-being. There are not many resources on the impact that abortion has on women, which is a big part of the problem. Abortion has been done 45 million times in this country since 1973, but there's very little study on the topic.

Abortion is a medical procedure. Women need to know as much information about this procedure as they do about any other med-

ical procedures. We would never tolerate restricted access to information about other medical procedures we are about to undergo.

Also, most post-abortion counseling, whether conducted at an abortion clinic, a pregnancy center, or in a counselor's office, is not long term. I fear that unless more research is done on the long-term emotional impact of abortion it will be difficult for many women to have access to post-abortion counseling and treatment if they decide they want it.

While the physical impact of abortion has been documented since Roe v. Wade, the long-term emotional impact to women has remained largely unexplored. Research on the emotional impact of giving birth, that is, postpartum depression, and miscarriage, has been very helpful in developing compassionate responses and treatment for women who are experiencing these changes in their lives, and I strongly support continued research on postpartum depression and miscarriage-related depression.

However, I believe that we also need to devote better resources to the research and treatment of post-abortion depression. No matter what pregnancy outcome a woman chooses, there should be help made available that speaks to the emotional issues that she may be encountering.

Mr. Chairman, I would like unanimous consent to insert for the record Doctor Shadigian's Senate testimony from the March 3, 2004 hearing, on the topic of abortion's impact on women, plus the studies she references in that testimony.

Mr. BILIRAKIS. Without objection.

Mr. PITTS. I notice that Doctor Shadigian's prepared testimony for today focuses on stress related to postpartum depression, and I'm grateful that we will be hearing one of those voices of women who have actually had abortions today, and I want to thank our witnesses, Michaelene Fredenburg and Doctor Elizabeth Shadigian for testifying today on this very important issue, and I look forward to their testimony, as well as the first panel, and yield back the balance of my time.

[The prepared statement of Hon. Joe Pitts follows:]

PREPARED STATEMENT OF HON. JOE PITTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, thank you for holding this hearing today. As you know, we talked long ago about the importance of this issue, and I am glad to see the hearing has finally come to fruition today.

I am going to keep my comments short and focus them on post abortion depression, since that is what my bill, HR 4543, The Post Abortion Depression Research and Care Act, addresses. However, this statement should not be construed as opposition to the other topic being discussed today.

Mr. Chairman, women have a right to know about the long-term effects of abortion on their mental and emotional well-being.

There are not many resources on the impact abortion has on women, which is a big part of the problem. Abortion has been done 45 million times in this country since 1973, but there is very little study on the topic.

Currently, there is no comprehensive system of data collection of psychological complications resulting from pregnancy, delivery or abortion.

Although the Centers for Disease Control (CDC) operate an abortion surveillance program that gathers information from state health departments and individual hospitals and clinics, these statistics are not comprehensive. I am sure our witnesses will comment on that further during their testimony.

Abortion is a medical procedure. Women need to know as much information about this procedure as they do about any other medical procedures.

We would never tolerate restricted access to information about other medical procedures we are about to undergo. Nor should we tolerate a lack of empirical evidence concerning the potential side-effects of an abortion.

It is widely acknowledged that medical procedures can affect not only the patient's physical state but the patient's mental state as well. We need to be able to document the potential emotional impact of abortion.

Also, most post-abortion counseling—whether conducted at an abortion clinic, a pregnancy center, or in a counselor's office—is not long term.

The limited follow-up that can be provided by an abortion clinic or pregnancy center is not a comprehensive source of non-anecdotal information about the emotional effects of abortion.

While using anecdotal information in a peer counseling session may be helpful, it does not provide the same benefits as empirical research. The nature of informed consent, now considered standard procedure, implies that a patient be informed of the potential side-effects of the procedure based on objective data, not anecdotal information.

Mr. Chairman I fear that unless more research is done on the long-term emotional impact of abortion, it will be difficult for many women to have access to post-abortion counseling and treatment, if they decide they want it.

Most of the advances in mental health in recent years have been preceded by an increased awareness of a specific mental health problem. Accurate research can foster awareness because it makes a problem concrete.

For instance, by comparing women with different pregnancy outcomes (miscarriage, live birth/biological mother raising child, live birth/adoption and abortion), we can better determine what potential emotional impact abortion produces relative to other pregnancy related decisions. This information may help us to determine early warning signs of depression for women who choose abortion so that these women can receive help as quickly as possible and not have to struggle alone for a long period of time.

I am hoping some of our witness will address this very issue today.

Further, Mr. Chairman, While the physical impact of abortion has been documented since Roe v. Wade, the long-term emotional impact of abortion has remained largely unexplored.

In recent years, the federal government has called for an increased focus on the issue of mental health. Now more than ever good mental health is part of the public debate. Why should women considering abortion deserve anything less than accurate information concerning the potential impact of abortion on their mental health? Why should women who have experienced abortion deserve any less than compassion—and even treatment—for whatever emotions they may be feelings in connection with their abortion?

And finally, research on the emotional impact of giving birth (i.e. post-partum depression) and miscarriage have been very helpful in developing compassionate responses and treatment for women who are experiencing these changes in their lives.

I strongly support continued research on post-partum depression and miscarriage-related depression. However, I believe that we also need to devote federal resources to the research and treatment of post-abortion depression. No matter what pregnancy outcome a woman chooses, there should be help made available that speaks to the emotional issues that she may be encountering.

Mr. Chairman I would like unanimous consent to insert for the record Dr. Shadigian's Senate testimony from the March 3, 2004 hearing on the topic of abortions impact on women plus the studies she references in that testimony. I noticed that Dr. Shadigian's prepared testimony for today focuses on stress related to post-partum depression.

I suspect that those who promote abortion do not want an honest study on this topic, but those who care about women should be demanding that we take a look at how abortion impacts women.

The way to start is to hear from women who have actually had abortions because their voice has not been heard.

I am grateful that we will be hearing one of those voices today. I want to thank our witnesses Michaelene Fredenburg and Dr. Elizabeth M. Shadigian, for testifying today on this very important issue.

I look forward to their testimony and yield back the balance of my time.

EMOTIONAL IMPACT OF ABORTION, MISCARRIAGE VARIES

By Amy Norton

NEW YORK (Reuters Health)—Although women who have an abortion may have a lesser immediate emotional reaction than those who miscarry, the long-term impact may be stronger for some, a new study suggests.

Researchers in Norway found that women who'd had an abortion two years earlier were more likely than those who'd miscarried to be suppressing thoughts and feelings about the event—although most women did not show this reaction.

Overall, nearly 17 percent of 80 women who'd had an abortion scored highly on a scale measuring such "avoidance" symptoms, compared with about three percent of those who'd miscarried.

That's in contrast to responses 10 days after the miscarriage or abortion, when nearly half of those who miscarried and 30 percent of those who had an abortion scored highly on measures of avoidance or "intrusion," which includes symptoms such as flashbacks and bad dreams.

The findings suggest that women who have an abortion or miscarriage should be encouraged to talk about their feelings instead of holding them inside, according to study leader Dr. Anne Nordal Broen.

"We know that suppression of thoughts and feelings connected to an event is not a healthy way to deal with difficult psychological responses," Broen, a specialist in psychiatry at the University of Oslo, told Reuters Health.

"It is better to talk about what happened, let the natural feelings come out," she said.

Broen and her colleagues report their findings in the journal Psychosomatic Medicine.

The study included 120 women between the ages of 18 and 45 treated at one Norwegian hospital; 80 had an abortion before the 14th week of pregnancy, and 40 miscarried in the first or second trimester. The women completed standard questionnaires on avoidance and intrusion symptoms 10 days, six months and two years after the miscarriage or abortion.

Broen's team found that women with strong feelings of shame, grief or loss at the first time point were more likely than others to have continuing symptoms of avoidance or intrusion two years out.

Broen said this suggests that doctors should be "extra observant" of such women over the long term, and be ready to provide them with more follow-up care. Family and friends, she noted, should also be prepared to give support."Women with a miscarriage or an induced abortion should be encouraged to talk and allow themselves to have feelings about what happened," she said.

SOURCE: Psychosomatic Medicine, March/April 2004.

PREPARED STATEMENT OF DR. ELIZABETH SHADIGIAN, GIVEN AT A SCIENCE, TECHNOLOGY, AND SPACE HEARING: IMPACT OF ABORTION ON WOMEN, WEDNESDAY, MARCH 3, 2004

M.D., Clinical Associate Professor, Department of Obstetrics and, University of Michigan Most of the medical literature since induced abortion was legalized has focused on short-term surgical complications, surgical technique improvement, and abortion provider training.

Long-term complications had not been well studied as a whole, until now, due to politics—specifically, the belief that such studies would be used either to limit or expand access to abortion. The two commissioned studies that attempted to summarize the long-term consequences of induced abortion concluded that future work should be undertaken to research long-term effects.

The political agenda of every researcher studying induced abortion is questioned more than in any other field of medical research. Conclusions are feared to be easily influenced by the author's beliefs about women's reproductive autonomy and the moral status of the unborn.

Against this backdrop of politics is also a serious epidemiological concern: researchers can only observe the effects of women's reproductive choices, since women are not exposed to induced abortion by chance. Because investigators are deprived of the powerful tool of randomization to minimize bias in their findings, research must depend on such well-done observational studies. These studies depend on information from many countries and include legally mandated registers, hospital administrative data and clinic statistics, as well as voluntary reporting (or surveys) by abortion providers.

Approximately 25% of all pregnancies (between 1.2-1.6 million per year) are terminated in the United States, so that if there is a small positive or negative effect of induced abortion on subsequent health, many women will be affected.

A recent systematic review article critically assesses the epidemiological problems in studying the long-term consequences of abortion in more detail. It should be kept in mind that: 1) limitations exist with observational research; 2) potential bias in reporting by women with medical conditions has been raised and refuted; 3) an assumption has been made that abortion is a distinct biological event; 4) inconsistencies in choosing appropriate comparison groups exist; and 5) other possible confounding variables of studying abortion's effects over time also exist.

Nonetheless, given the above caveats, my research, which included individual studies with no less than 100 subjects each, concluded that a history of induced abortion is associated with an increased long-term (manifesting more than two months after the procedure) risk of: 1) breast cancer 2) placenta previa 3) preterm birth and 4) maternal suicide.

Outcomes Not Associated with Induced Abortion

Induced abortion has been studied in relation to subsequent spontaneous abortion (miscarriage), ectopic pregnancy, and infertility. No studies have shown an association between induced abortion and later spontaneous abortion. An increase in ectopic or tubal pregnancies was seen in only two out of nine international studies on the topic, while only two out of seven articles addressing possible subsequent infertility showed any increased risk with induced abortion.

OUTCOMES ASSOCIATED WITH INDUCED ABORTION

1. Breast Cancer

Based upon a review of the four previously published systematic reviews of the literature and relying on two independent meta-analyses, (one published and one unpublished), induced abortion causes an increased risk of breast cancer in two different ways. First, there is the loss of the protective effect of a first full-term pregnancy ("fftp"), due to the increased risk from delaying the fftp to a later time in a woman's life. Second, there is also an independent effect of increased breast cancer risk apart from the delay of fftp.

The medical literature since the 1970s has shown that a full-term delivery early in one's reproductive life reduces the chance of subsequent breast cancer development. This is called "the protective effect of a first full term pregnancy (fftp)." This is illustrated in Figure 1 which uses the "Gail Equation" to predict the risk of breast cancer for an 18 year-old within a five-year period and also within a lifetime. The Gail Equation is used to help women in decision-making regarding breast cancer prevention measures.

In the first scenario, the 18 year-old decides to terminate the pregnancy and has her fftp at age 32, as compared to the 18 year-old in the second example who delivers at term. The individual risk of these women is then assessed when the risk of breast cancer peaks. As figure 1 shows, having an abortion instead of a full-term pregnancy at age 18 can almost double her five-year and lifetime risk of breast cancer at age 50, regardless of race.

An independent effect of increased breast cancer risk apart from the delay of first full-term pregnancy has been controversial. Four published review articles have been written. Two of the reviews found no association between induced abortion and breast cancer, while one paper found a "small to non-significant effect." The sole published meta-analysis reported an odds-ratio ("OR") for breast cancer of 1.3 (or 95% CI=1.2, 1.4) in women with a previous induced abortion. One yet unpublished independent meta-analysis found the OR=1.21 (95% CI=1.00, 1.45). Brind et al. used older studies and translated non-English ones. He did not exclude any studies and used a different statistical approach. The unpublished study used exclusion criteria and only English language studies. Another finding was that breast cancer is increased if the abortion is performed before a first full term pregnancy. Brind found an OR=1.4 (95% CI=1.2, 1.6), while the unpublished study showed an OR=1.27 (95% CI=1.09-1.47). The two meta-analyses used different methodologies, but reported nearly equivalent results, which are statistically significant, and do show that induced abortion is a independent risk factor for breast cancer.

Some other findings from individual research papers included in my review concluded that the risk of breast cancer increases with induced abortion when: (a) the induced abortion precedes a first full term pregnancy; (b) the woman is a teen; (c) the woman is over the age of 30; (d) the pregnancy is terminated at more than 12 weeks gestation; or (e) the woman has a family history of breast cancer. One re-

searcher (Daling) also reported, in her study, that all pregnant teens with a family history of breast cancer who aborted their first pregnancy developed breast cancer.

2. Placenta Previa

"Placenta previa" is a medical condition of pregnancy where the placenta covers the cervix, making a cesarean section medically necessary to deliver the child. In general, this condition puts women at higher risk, not just because surgery (the c-section) is necessary, but also because blood loss is higher, and blood transfusions may be necessary. There is also a higher risk of hysterectomy (the loss of the uterus), and therefore the need for more extensive surgery.

Three studies with over 100 subjects each were found examining induced abortion and placenta previa, as well as one meta-analysis. The three studies found a positive association, as did the meta-analysis. Induced abortion increased the risk of placenta previa by approximately 50%.

3. Pre-Term Birth ("PTB")

Twenty-four studies explored associations between abortion and pre-term birth or low birth weight (a surrogate marker for pre-term birth). Twelve studies found an association which almost doubled the risk of preterm birth. Moreover, seven of the twelve identified a "dose response effect" which means a higher risk for pre-term birth for women who have had more abortions.

"Also notable is the increased risk of very early deliveries at 20-30 weeks (full-term is 40 weeks) after induced abortion, first noted by Wright, Campbell, and Beazley in 1972. Seven subsequent papers displayed this phenomenon of mid-pregnancy PTB associated with induced abortion. This is especially relevant as these infants are at high risk of death shortly after birth (morbidity and mortality), and society expends many resources to care for them in the intensive care unit as well as for their long-term disabilities. Of particular note are the three large cohort studies done in the 1990s, 20 to 30 years after abortion's legalization. Each shows elevated risk and a dose response effect. Because these studies were done so long after legalization, one would assume that the stigma of abortion that might contribute to under-reporting would have waned."

4. Suicide

Two studies have shown increased rates of suicide after induced abortion, one from Finland and one from the United States. The Finnish study (by Gissler et al.) reported an OR=3.1 (95%CI=1.6,6.0) when women choosing induced abortion were compared to women in the general population. The odds ratio increased to 6.0 when women choosing induced abortion were compared to women completing a pregnancy. The American study (by Reardon et al.) reported recently that suicide RR=2.5 (95%CI=1.1, 5.7) was more common after induced abortion and that deaths from all causes were also increased RR=1.6 (95%CI=1.3, 7.0).

In addition, self-harm is more common in women with induced abortion. In England psychiatric hospital admissions because of suicide attempts are three times more likely for women after induced abortion, but not before.

Maternal Mortality

There is no mandatory reporting of abortion complications in the U.S., including maternal death. The Centers for Disease Control (CDC) began abortion surveillance in 1969. However, the time lag in CDC notification is greater than 12 months for half of all maternal deaths. Maternal deaths are grossly underreported, with 19 previously unreported deaths associated with abortions having been identified from 1979-1986. The CDC quotes approximately one maternal death for every 100,000 abortions officially, which is death between the time of the procedure and 42 days later. Therefore, statements made regarding the physical safety of abortion are based upon incomplete and inaccurate data.

Many women are at much higher risk of death immediately after an induced abortion: for example, black women and minorities have 2.5 times the chance of dying, and abortions performed at greater than 16 weeks gestation have 15 times the risk of maternal mortality as compared to abortions at less than 12 weeks. Also, women over 40 years old, as compared to teens, have three times the chance of dying.

Late maternal mortality, which includes deaths occurring after the first 42 days following abortion are not reflected in CDC numbers, nor are data from all 50 states, because reporting is not currently mandatory. To accurately account for late maternal mortality, maternal suicides and homicides, breast cancer deaths and increased caesarian section deaths from placenta previa and pre-term birth would also be included with other abortion-related mortality.

Informed Consent

Health care providers are obliged by law to inform patients of the benefits and risks of the treatment being pondered before a medical decision is made. In the case of a woman deciding to terminate a pregnancy, or undergoing any surgery or significant medical intervention, informed consent should be as accurate as possible.

Induced abortion is associated with an increase in breast cancer, placenta previa, pre-term birth and maternal suicide. Maternal deaths from induced abortion are currently underreported to the Centers for Disease Control. These risks should appear on consent forms for induced abortion, but currently are not.

American College of Obstetricians and Gynecologists (ACOG)

In the most recent edition of medical opinions set forth by the American College of Obstetricians and Gynecologists (Compendium of Selected Publications, 2004, Practice Bulletin #26), ACOG inexplicably states:

> "Long-term risks sometimes attributed to surgical abortion include potential effects on reproductive functions, cancer incidence, and psychological sequelae. However, the medical literature, when carefully evaluated, clearly demonstrates no significant negative impact on any of these factors with surgical abortion." (Italics added for emphasis)

I am a proud member and fellow of ACOG. Because of groups like ACOG American women enjoy some of the best health, and health care, in the world. However, I am deeply troubled that ACOG makes assurances to their membership, and to women everywhere, claiming a lack of long-term health consequences of induced abortion. Instead, ACOG should be insisting that these long-term health consequences appear on abortion consent forms.

Why doesn't ACOG insist that long-term health consequences of induced abortion be included?

ACOG seems to claim that they have adequately evaluated the medical literature, but they do not consider our study nor the many older studies we evaluated. This situation is akin to the early studies that indicated that cigarette smoking was linked to heart disease and lung cancer in the 1950's and 1960's. Eventually, larger, improved studies were funded that could thoroughly assess the health effects of smoking. We are at a similar crossroads for women today—just as we were regarding smoking and long-term health effects in the 1950's and 1960's.

Conclusion A clear and overwhelming need exists to study a large group of women with unintended pregnancies who choose—and do not choose—abortion. If done properly, a dramatic advance in knowledge will be afforded to women and their health care providers—regardless of the study's outcome. A commitment to such long-term research concerning the health effects of abortion including maternal mortality would seem to be the morally neutral common ground upon which both sides of the abortion/choice debate could agree.

In the meantime, there is enough medical evidence to inform women about the long-term health consequences of induced abortion, specifically breast cancer, placenta previa, pre-term birth, and maternal suicide. They should also be informed of the inadequate manner in which maternal death is reported to the government, thus grossly underestimating the risk of death from abortion.

I applaud this subcommittee for taking on such a politically difficult topic in an effort to show women the respect they deserve by supplying them with accurate medical information.

Mr. BILIRAKIS. The Chair thanks the gentleman.

The gentlelady from Colorado, Ms. DeGette, for an opening statement.

Ms. DEGETTE. Thank you, Mr. Chairman.

I would like to at least thank the Chairman for agreeing to two separate panels today, for what are clearly two very separate issues.

At first, I was perplexed why these two bills were being lumped together at one hearing. But then I realized, well, they both deal with women, pregnancy and depression, so what the heck, I guess they must be the same.

Unfortunately, though, what the hearing does, it conflates one issue on which there is broad scientific evidence, and that one is postpartum depression, and it conflates it with a highly specious

topic with almost no scientific basis, that of so-called post-abortion syndrome.

Now, I can understand attempts to muddy the waters, but let's not mistake and confuse these two issues. To do so would be to fall victim to the worst sort of rhetorical folly and political theater, and I know that that is not in the best interest of this committee or this Congress.

As my colleagues have pointed out, professional medical associations have concluded that so-called post-abortion syndrome does not exist. Neither the American Psychological Association, nor the American Psychiatric Association's DSM IV, the definitive manual of mental illnesses and psychological phenomena, recognize so-called post-abortion syndrome or any related category as an identifiable mental health condition.

Further, the American Psychological Association assembled a panel of experts in 1989 to review the evidence of psychological risks of abortion. The panel unanimously concluded that legal abortion, "does not create psychological hazards for most women undergoing the procedure," and that there is no evidence of such an epidemic. That was in 1989. Since that time, there has been no significant change in this point of view.

By way of contrast, of course, postpartum depression, has been widely recognized in the medical profession. Every year over 400,000 women suffer from postpartum mood changes with baby blues affecting up to 80 percent of new mothers. Postpartum mood and anxiety disorders impair around 10 to 20 percent of new mothers, and postpartum psychosis strikes one in 1,000 new mothers. This is a serious problem.

I'd like to thank my colleague, Mr. Rush, for bringing it to our attention. I think that we should really be looking as a Congress for ways that we can help all of these women with an identifiable medical problem that really needs to be solved.

And, in conclusion, as the Co-Chair of the Pro Choice Caucus in Congress, I know we work on these difficult and complex issues. And so, therefore, I do look forward to hearing the testimony, but I think we should keep our eye on scientific reality and avoid political rhetoric.

Thank you.

Mr. BILIRAKIS. The Chair recognizes the gentleman from Mississippi, Mr. Pickering, for an opening statement.

Mr. PICKERING. Mr. Chairman, I thank you for having this hearing, and I think the issues of postpartum depression, as well as post-abortion depression, are something that we need to understand as a Nation and as a people, to be able to address those needs both emotionally, psychologically, and from a health perspective. There must be policies and forms of assistance to mothers at this critical time.

So, I thank you for this hearing, I look forward to hearing the testimony today.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Towns, the gentleman from New York, for an opening statement.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me begin by thanking you for holding this hearing, and thanking my good friend and colleague, Bobby Rush, for pushing for the hearing, and to thank the chairman of the full committee for also agreeing that the hearing should take place after the commitment was made by the former chairman. So, I want to thank all of you for that.

And also, I encourage us to move forward with an open mind, let's move forward in a team approach, because this is a serious problem, and we have to recognize that. And, I think that if we have an open mind that we can listen to our witnesses, Doctor Stotland, and, of course, Ms. Blocker, and maybe we can learn something and be able to do something that might be able to save a lot of people, because as you know this issue is out there, and we need to address it in a very strong and professional manner.

You know, I am very concerned about it. I'm a trained social worker by profession, so I have a real interest in this, because I know that there's a lot of people out there that are suffering and that we can do something about it by having the proper legislation here in the House.

And, I think that Mr. Rush's legislation will be able to assist us in that, but here again we need to hear from our witnesses with an open mind and be in a position to take that information and try and make the bill as strong as we possibly can, because we are dealing with families. A lot of people are hurting. And, of course, we need to try to eliminate pain whenever we can.

I think that's why people send us here, I think they send us to Congress to do that. I think that we need to sort of keep that in mind, and we should not make this political. I mean, this is more than that. I think that to try and jump on from a political point of view, would be providing a great disservice to so many people in this country.

So, I'm hoping that on both sides of the aisle that you will hold your powder and open your ears and listen.

Thank you, and I yield back.

Mr. BILIRAKIS. And, I thank the gentleman for his very wise statement, and I, too, am appreciative to Mr. Rush for bringing this. I mean, this is a real world problem, and he has been a strong proponent of the issue for a long, long time. We should appreciate the fact that he's making us much more aware of it than maybe we were before.

I will say that in the past we have often held hearings where we mixed issues, if you will, and in the interest of time and that sort of thing, so I don't know why, you know, there happens to be a problem here that we've decided to put these two issues together. They are both involving, obviously, post pregnancy depression and both involve women. So, yes, this is why we've done what we have.

Mr. Green, for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman and Ranking Member Brown, for holding this hearing to examine depression and mental health after pregnancy.

My statement and witness questions today are focused primarily on postpartum depression, the pervasive condition that deserves the full attention of this subcommittee, without being clouded by politically motivated discussion about abortion.

Postpartum depression affects a majority of American families in one way or another, whether it's in the form of the baby blues, clinical depression or psychosis.

In my hometown of Houston, we learned all too well the dangers as a result of undiagnosed or mistreated postpartum depression. In 2001, Andrea Yates drowned her five children and was sentenced to life in prison in Texas. A native Houstonian, and valedictorian of Milby High School in my district, Andrea had everything going for her and a bright future as a registered nurse at the top cancer center in the country. Yet, Andrea's adult years were filled with warning signs about her tendencies toward depression and psychosis. Because of her history of suicide attempts, hospitalizations, drug therapies for her depressive episodes, doctors warned her that additional children would spark more psychotic behavior. Nevertheless, she became pregnant a fifth time and stopped her drug therapy.

We all know the unfortunate end to this story which shocked not only my community in Houston, but our nation. Sadly, families all across America are dealing with effects of postpartum depression and psychosis, and they are not getting the help they need.

In general, women aren't getting the information they need to detect the warning signs of postpartum depression, and I would suggest that also to their husbands, families and support networks are left feeling helpless about what they can do to help their loved ones, and access to mental health care is severely lacking.

As members of the subcommittee, however, we can take action, not only with this legislation today, but a majority of this Congress has co-sponsored Representative Kennedy's bill to provide equal insurance coverage for mental health benefits, and we know the support is there, so let's pass this bill and put our money where our mouths are, when it comes to supporting access to mental health care.

In the meantime, however, we must realize the importance of awareness. I know a young woman who suffered from postpartum depression, yet resisted treatment because she thought of herself simply as a bad mother. These thoughts resulted, not only from the depression, but also from the stigma that unfortunately still exists within our society when it comes to mental illness. Through education and awareness, we can make significant strides toward helping postpartum mothers identify their depression, seek the treatment they need, and get them on their way toward developing that all too important bond with their new children.

I want to thank our witnesses for appearing today, and particularly appreciate Ms. Blocker's willingness to share her family's story with the subcommittee. I can only imagine the pain that you must relive each time you tell your daughter's story. However, please know that you are doing a world of good in educating us and the public about this important issue.

Thank you, Mr. Chairman, I yield back my time.

Mr. BILIRAKIS. I thank the gentleman.

Ms. Capps, for an opening statement.

Ms. CAPPS. Thank you, Mr. Chairman. I appreciate the opportunity to look at the issue of postpartum depression.

Approximately, 400,000 women will experience postpartum depression this year. So many of them don't even know that they need help. A condition that can put such terrible strain on families just at the time when they expect to be able to revel in the joy of the birth of a child.

As a nurse for many years, I've seen firsthand how much women, their families, and their partners, struggle with this difficult condition. Unfortunately, it's been noted there is a great stigma associated with postpartum depression, as many women feel so ashamed of the feelings that they are experiencing, which mainly comes about because so many of us don't fully understand the condition.

In the 106th Congress, I worked with Congressman Jack Kingston to pass a resolution in the Congress to bring more attention to this condition, and I want to publicly acknowledge a constituent of mine, Jane Honiquan, who founded, a couple decades ago, Postpartum Depression International, and has worked so tirelessly to remove the stigma from the situation.

The resolution we passed here called on hospitals to provide new mothers with information on this problem before their discharge. I'm so proud this year to co-sponsor Mr. Rush's bill to instruct NIH and the National Institutes of Mental Health to expand their research into postpartum depression and to provide grants for support services, and I commend Mr. Rush's constituent for being willing to talk about this issue today.

However, this hearing seems to be equating the documented illness of postpartum depression with that of a so-called post-abortion depression. It's so unfortunate, because there is little, if any, evidence in the scientific literature that post-abortion depression exists.

For example, Surgeon General C. Everett Koop conducted an exhaustive review of the science on this issue, despite intense political pressure and his own views opposing choice, he found that the psychological effects of abortion are minuscule from a public health perspective.

The American Psychological Association, the Journal of American Medical Association likewise, has found no evidence of post abortion depression, and the American Psychological Association's DSM-IV, the definitive manual on mental illness, does not have a category, does not even recognize post abortion depression. That's not to say that women facing a troubled or unwanted pregnancy, including those who choose termination, do not suffer great anguish, and many of them, some of them may have pre-existing depression.

Despite anti-choice rhetoric to the contrary, choosing an abortion, choosing to have an abortion, is not a decision that women take lightly. Indeed, it is precisely the gravity with which women approach this issue that should give politicians and anti-choice activists pause before they choose to dictate the choices that should be made for women.

Like the unsubstantiated claims linking breast cancer to abortion, the claims of abortion causing mental illness are just another weapon, a political ploy, in the fight to make all abortions illegal. It's truly unfortunate because there are women who do need our help, whether they choose to carry their pregnancies to term or not.

Our time would be much better spent helping them, rather than looking for another reason to take the right of choice away from them.

Thank you.

Mr. BILIRAKIS. The Chair thanks the gentlelady.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. CHARLIE NORWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Thank you Chairman Bilirakis for calling this subcommittee hearing to discuss issues concerning "women's health." Of course, we all know that women's health is everyone's health.

Pregnancy is a powerful event in every woman's life—and it can have lasting effects. Unfortunately, some the effects can be negative, such as depression or postpartum psychosis. I believe today's hearing will be extremely enriching because the aforementioned diseases afflict many women during and after their pregnancy. For instance, many don't know that most mothers fight a bout with "baby blues;" one in ten mothers are diagnosed with postpartum depression; and an estimated one to 500 to 1,000 mothers are diagnosed with postpartum psychosis. The most unfortunate fact is that these diseases are often terribly under-diagnosed. I am pleased that we are doing our part to discuss these issues and advance the issues of women's health. I am sure that all of here would agree that in order to have a health society, we must have healthy women.

I look forward to hearing from the witnesses before this committee today, and I yield back the balance of my time.

Mr. BILIRAKIS. Let's move on to our panel now.

Ms. Blocker and Doctor Stotland, your written statement is a part of the record, we would hope that you would sort of supplement it, complement it, if you will, orally.

Ms. Blocker, we'll start off with you, and we'll set the clock at 5 minutes. Please proceed, Madam. And again, thank you for having the courage to be here.

STATEMENTS OF CAROL BLOCKER; AND NADA L. STOTLAND, PROFESSOR OF PSYCHIATRY AND PROFESSOR OF OBSTETRICS AND GYNECOLOGY, RUSH MEDICAL COLLEGE

Ms. BLOCKER. Okay.

Mr. Chairman and members of the subcommittee, my name is Carol Blocker, and I am the mother of Melanie Blocker Stokes. My daughter took her life on June 11, 2001, less than 5 months after giving birth to her first daughter, my grandchild, Sommer Skyy. I am here this afternoon to ask for the committee's support for H.R. 846, the Melanie Blocker Stokes Postpartum Depression Research and Care Act, introduced on February 13, 2003 by Congressman Bobby Rush, a distinguished member of this committee.

Congressman Rush introduced this legislation after hearing my daughter's story, which I would like to share with the members of the committee today.

My daughter, Melanie, was born and raised in the city of Chicago. As both a child and an adult, she was beautiful, accomplished, and the light of my life. We educated her at St. George private school in Hyde Park, she went to the Immaculata High School in Chicago, and Spelman College in Atlanta, Georgia. After she completed Spelman College, Melanie returned home to Chicago and went to work for Astra Zeneca Pharmaceutical Company, where she rose to become a sales manager, and she married Doctor Sam Stokes.

Sam and Melanie were so happy in their marriage and their lives together, and even happier when they learned, in 2000, that a child was on the way. The whole family, Sam's family and ours, were ecstatic when my granddaughter—who Melanie named Sommer Skyy—was born on February 23, 2001, and my daughter's pregnancy was normal.

But, 6 weeks after my daughter gave birth, at the routine postpartum checkup, she said that she felt "hopeless" and she retreated to her room. We couldn't get her to go back to the doctor, or back to her job, or back into the world.

One day I found Melanie in her bedroom and she was hollow-eyed and gaunt, and she was rocking in her glider. Her lips and her tongue were peeling from malnutrition, because Melanie was not eating or sleeping normally. When I went to her bathroom to get her a cold towel, I found a butcher's knife, and I asked Melanie, I said, "What are you doing with this?" She looked at me and said she didn't know, but she thought she was going to have to die.

At that moment, I knew that something was very, very wrong with Melanie and I called her doctor, and he said, well, she's suffering from postpartum depression.

Over the next 7 weeks Melanie was hospitalized three times, and each time the doctors prescribed different combinations of anti-depression, anti-anxiety and anti-psychotic medications, but Melanie's depression had deepened to the point that she wouldn't or couldn't take the pills. She talked about suicide and looked for ways to harm herself. Once she even asked her brother to buy her a gun. Another time she took the screens out of my high-rise apartment windows while visiting me.

And another time we found that she had snuck away from her home and tried to drown herself in Lake Michigan. Each time we went back to the doctor sand each time there were more prescriptions and more assumptions, but we never heard the words postpartum psychosis.

When Melanie came home after her third stay in the hospital she seemed to be a bit better, but I was still worried, and my fears were founded.

On the night before Melanie's disappearance, I told her husband Sam, "Don't you let her out of your sight." But Sam had to leave for a meeting the next morning, and when he left the apartment Melanie fled. The day was June 10, 2001, less than 6 months after Sommer Skyy was born.

We searched Chicago looking for her all weekend. We posted flyers and Sam went on the local television, on the news, pleading, "Melanie, please come home. I need you. You baby needs you." But Melanie didn't answer.

While we searched, Melanie went to a hotel in Chicago and talked a clerk into letting her into a room on the twelfth floor. She then wrote six suicide notes. The notes included one to God and one to Sam, and all six of them were lined up on the night stand in her room. We found them after she died.

On June 11, 2001, as the sun rose over Lake Michigan, my beautiful daughter stepped out of a window on the twelfth floor of a hotel to her death. And I think my heart died that day.

After hearing my daughter's story, Congressman Rush, a member of this distinguished committee, asked me what could have been done to prevent my daughter's tragic end, and what additional resources were needed to help physicians and families to recognize, understand and treat this terrible syndrome—postpartum psychosis—that affects about one in 1,000 new mothers. The symptoms, many which my daughter exhibited, including losing touch with reality, distorted thinking, delusions, hyperactivity and mania. The psychosis became like a monster that entered my daughter's brain, and it could not be controlled.

Even in the milder forms of postpartum depression, this disease manifests itself with lack of interest in a newborn child, fear of harming the child, fatigue, sadness, hopelessness, guilt, inadequacy and worthlessness. Some research indicates that between 50 percent and 75 percent of all new mothers suffer with these "baby blues," yet little is known about how we, as families, can prevent the tragedy that fell on my family.

From our discussions, and from discussions with many physicians and health practitioners, he developed and introduced the Melanie Blocker Stokes Postpartum Depression Research and Care Act. The legislation will expand and intensify research in the National Institutes of Health and National Institutes of Mental Health on the causes, diagnoses and treatments of postpartum depression and postpartum psychosis. The bill will also provide money to deliver services to individuals and their families who suffer from a postpartum depression and postpartum psychosis.

Mr. Chairman, if this legislation had been in place in 2001, maybe we would have been able to recognize my daughter's trouble and prevent her death. Maybe my granddaughter would have her mommy today. My granddaughter calls both me and her aunt, "Mama," and we are mothering her with all of the love and energy that we have. But I notice that when other people look at Sommer, and they know her story, there is sadness in their eyes. They know, like I know, that Sommer deserved to have a mother, and her mother deserved to have her daughter.

Mr. Chairman and members, I hope and pray that this committee will finally act on this legislation to spare countless of other women and their families from the horrible consequences of this disease.

Thank you.

[The prepared statement of Carol Blocker follows:]

PREPARED STATEMENT OF CAROL BLOCKER

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At that moment, I knew that something was very, very wrong with Melanie and I called her doctor, who said that she was suffering from postpartum depression—two words that I had never heard before.

Over the next seven weeks, Melanie was hospitalized three times—each time the doctors prescribed different combinations of antidepressant, anti-anxiety and anti-psychotic medications. But, Melanie's depression had deepened to the point that she wouldn't—or couldn't—take her pills. She talked about suicide and looked for ways to harm herself. Once, he asked her brother to buy her a gun.

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From our discussions, and from discussions with many physicians and health practitioners, he developed and introduced the Melanie Blocker Stokes Postpartum Depression Research and Care Act. The legislation will expand and intensify research at the National Institutes of Health and National Institutes of Mental Health on the causes, diagnoses and treatments of postpartum depression and postpartum psychoses and provide money to deliver services to individuals and their families who suffer from a postpartum depression and postpartum psychosis.

Mr. Chairman, if this legislation had been in place in 2001, maybe we would have been able to recognize my daughter's trouble and prevented her death. Maybe my granddaughter would have her mother today. My granddaughter calls both me and her aunt, "Mama," and we are mothering her with all of the love and energy that

we have. But, I notice that when other people look at Sommer, and they know her story, there is sadness in their eyes. They know, like I know, that Sommer deserved to have a mother—and her mother deserved to have her daughter.

Mr. Chairman and members, I hope—I pray—that this Committee will finally act on this legislation to spare countless of other women and their families from the horrible consequences of this disease.Thank you.

Mr. BILIRAKIS. Thank you so much, Ms. Blocker.

Doctor Stotland, proceed.

STATEMENT OF NADA L. STOTLAND

Ms. STOTLAND. Good afternoon, Chairman Bilirakis and members. I am Nada Stotland, M.D. I'm a psychiatrist speaking today on behalf of the American Psychiatric Association and Physicians for Reproductive Choice and Health. And, as was mentioned, I'm Professor of Psychiatry and Obstetrics and Gynecology at Rush Medical College in Chicago.

My written testimony addresses the general epidemiologic data about mental illness in women. As you know, this is a major national health problem. I commend the subcommittee for focusing in general on post-pregnancy mental health in women, and particularly, I greatly appreciate the leadership of my own Congressman, Representative Bobby Rush, in calling attention to the consequences of untreated postpartum depression.

We tend to use psychiatric terms, such as depression and psychosis, imprecisely, so let me briefly discuss these illnesses in the context of the Diagnostic and Statistical Manual of Mental Disorders, the internationally recognized standard for the diagnosis of mental disorders. Depression is classified in DSM by severity, recurrence and association with mania. Major depression is a serious illness typified by a depressed mood most of the day, nearly every day, for at least 2 weeks, markedly diminished interest or pleasure in nearly all activities, weight loss or increased appetite, insomnia or hypersomnia, fatigue and recurrent thoughts of death or suicide.

Psychosis is part of a severe mental disorder and is characterized by a person's gross impairment in perceiving reality. A psychotic person may be delusional, or may experience hallucinations, disorganized speech, or disorganized or catatonic behavior.

With those definitions in mind, I'd like to say a quick word about postpartum disorders before discussing "so-called post-abortion depression and psychosis."

Today we know that disturbances can occur in the postpartum period in the form of transeunt baby blues, or much more seriously as postpartum depression and psychosis. As you have heard today, left undiagnosed or untreated, the consequences of postpartum psychosis can be horrific. We need more attention to these illnesses, particularly in populations that traditionally have restricted access to health and mental health care. So-called "post-abortion depression and psychosis" are, however, created designations by those who believe that abortions can have a long-term impact on the mental health of humans who elect to terminate a pregnancy.

In fact, data clearly shows that the vast majority of women have abortions without psychiatric sequelae. Even C. Everett Koop, M.D., who was President Reagan's Surgeon General and was personally very much opposed to abortion, found that, "The psychological effects of abortion are minuscule from a public health per-

spective." This is clear. Abortions are not a significant cause of mental illness.

The psychological outcome of abortion is optimized when women are able to make decisions on the basis of their own values, beliefs and circumstances, free from pressure or coercion, and to have those decisions supported by their families, friends and society in general.

This is not to say that there aren't any women who feel deeply distressed about having abortions, but it does not follow that there is a causal link between abortion and severe mental or physical illness. Self-selected accounts of post-abortion distress, however personally compelling, are not scientific studies. Unwanted pregnancy is a major stressor in a woman's life. The strongest predictors of poor post-abortion psychological outcomes is a pre-pregnancy history of depression. Other factors can include whether the pregnancy is terminated because of medical or genetic risks or complications, or a feeling that the decision to abort was not freely made.

Let me make a few specific observations about many of the primary arguments put forward by some who support this unscientific nomenclature of "post-abortion depression" and so-called "post-abortion psychosis." First of all, the terms confuse emotions with psychiatric illnesses. Sadness, grief and regret follow some abortions for very understandable reasons. These are not diseases. Again, the literature shows that abortion does not result in post-abortion psychopathology.

Second, supporters of this nomenclature do not distinguish women who terminate unwanted pregnancies from those who have to terminate wanted pregnancies because of threat to their own health, or serious malformations in their fetuses. These circumstances are stressors independent of the abortion itself.

Next, the arguments overlook an obvious reality: only pregnant women have abortions. These arguments fail to compare the aftereffects of abortion with the aftereffects of pregnancy, labor and child birth. Full-term pregnancy is associated with considerably greater medical and psychiatric risk than with abortion.

Next, assertions that abortion causes mental illnesses do not take into account the reasons women become pregnant when not intending to have babies, and the reasons pregnant women decide to have abortions, nor do they acknowledge that pre-existing mental health issues can have a significant impact on post-abortion outcomes, the most powerful impact.

And last, some articles I've seen assume that all women who have abortions require mental health intervention. There is simply no evidence that women seeking abortions need more mental health intervention than people facing other medical procedures.

With regard to general health issues, there is much misinformation about medical sequelae of abortions. Breast cancer is a good example. The most highly regarded, and methodologically sound study, on the purported link between abortion and breast cancer, indicates that there is no relationship between induced abortion and breast cancer.

Mr. Chairman, as a woman, as a physician, and particularly as a psychiatrist, I have great sympathy and compassion for all of my

patients, women and men, adults and adolescents, who struggle with mental illnesses, but we don't do women any favors when we encourage the representation as psychiatric disorders, those alleged conditions which data show have little basis in fact. Confusing feelings of sadness and regret with psychosis is not helpful to the profession or to the millions of women coping with mental illness.

Today, too many women, men and children, needing treatment for mental illnesses lack access to adequate mental health services. If this Congress wants to take one single action that would make a world of difference for all women, for all persons, needing mental health care, I respectfully suggest that Congress should promptly pass legislation to end discriminatory coverage of treatment of mental illnesses.

Thank you again for the opportunity to speak with you today. I would be happy to answer any questions you or other members of the subcommittee may have. Thank you.

[The prepared statement of Nada L. Stotland follows:]

PREPARED STATEMENT OF NADA L. STOTLAND, PROFESSOR OF PSYCHIATRY AND PROFESSOR OF OBSTETRICS AND GYNECOLOGY, RUSH MEDICAL COLLEGE

Good afternoon, Chairman Bilirakis, Ranking Member Brown, and members of the Health Subcommittee. Thank you for allowing me to appear before you today.

My name is Nada L. Stotland, M.D. I hold Doctor of Medicine and Master of Public Health degrees and have been a practicing psychiatrist for more than 25 years. Currently, I have a private clinical practice and am also Professor of Psychiatry and Professor of Obstetrics and Gynecology at Rush Medical College. I have devoted most of my career to the psychiatric aspects of women's reproductive health care.

I speak today on behalf of the American Psychiatric Association (APA), where I presently serve as an elected member of the Board of Trustees. APA is the medical specialty society representing more than 35,000 psychiatric physicians nationwide. Our members are on the front lines of treating mental illness across the country. They serve as clinicians, academicians, researchers, and administrators. I also speak today as a Board member of Physicians for Reproductive Choice and Health (PRCH), which represents more than 6,300 physician and non-physician members nationally. PRCH is a national not-for-profit created to enable concerned physicians to take a more active and visible role in support of universal reproductive health. PRCH is committed to ensuring that all people have the knowledge, access to quality services, and freedom of choice to make their own reproductive health decisions.

By way of personal background, my interest began with the psychology of pregnancy, labor, and childbirth. I gave birth to four wonderful daughters, now adults, and I was determined that their births be as safe as possible. I studied methods of prepared childbirth, used them, and became the Vice President of the national Lamaze prepared childbirth organization.

I commend the Subcommittee for holding this important hearing and for attempting to keep the focus on a general discussion of post pregnancy mental health in women. Let me say at the outset that I appreciate the Chairman's stated hope that we can explore the frank differences between some of the witnesses with a mutually respectful examination of the facts.

Before I begin my testimony, I want to take a brief moment to say that I was delighted to meet with my Congressman—Representative Bobby Rush—before today's hearing, and I was pleased to have been invited by Representative Rush to speak before the Congressional Black Caucus symposium on postpartum depression in 2001. I greatly appreciate his leadership on this vital issue, particularly with respect to the impact of untreated depression in minority populations, including minority women. This is an important and sorely neglected issue.

Mental Health Issues and Women:

Before focusing on post-pregnancy depression, it would be useful to discuss some general issues related to women's mental health. Burt and Hendrick, writing in their "Concise Guide to Women's Mental Health," put it succinctly, noting that "Women use more health care services than any other group in the United States. They make more visits to doctors' offices than do men, fill more prescriptions, have more surgeries . . . and spend two out of every three health care dollars."

Specific gender differences in the prevalence of mental illnesses in the United States are well recognized. This is true of prevalence rates for some disorders, but also in the way in which some disorders present at the diagnostic interview, and also in comorbidities. For example, not only are depression and dysthymia (a chronic form of depression) more common in women than men, but both are more likely to be accompanied by anxiety disorders in women than men. And the features of psychiatric illnesses present in women are likely to be different than when present in men.

The landmark Surgeon General's Report on Mental Health, issued by then-Surgeon General David Satcher, M.D., in 1999, provides much valuable information. Anxiety disorders (panic disorder, phobias, obsessive compulsive disorder, panic disorder, PTSD, etc.) are the most prevalent disorders in adults and are found twice as often in women as in men. Panic disorder is about twice as common among women as men, with the most common age of onset between late adolescence and mid-adult life. In the general (non-military) population, the one-year prevalence rate of posttraumatic stress disorder is about 3.6 percent, with women accounting for nearly twice the prevalence as men. The highest rates of PTSD are found among women who are the victims of crime, especially rape.

Mood disorders take a huge toll in the form of human suffering, lost productivity and suicide. They rank among the top ten disabling conditions worldwide. The most familiar mood disorders include major depression, dysthymia and cyclothymia (alternating depression and manic states that do not rise to the level of bipolar disorder). Again, with the exception of bipolar disorder, mood disorders are twice as common in women as in men, and in the case of seasonal affective disorder (depression occurring in the late fall and winter), seven times more common in women than men. Victims of domestic violence (an estimated 8 to 17 percent of women in the United States each year) are at increased risk for mental health problems. The mental health problems of domestic violence include depression, anxiety disorders including as noted PTSD, eating disorders, substance abuse and suicide.

Few would doubt the huge impact of depression alone on society and on the economy. Major depression is a seriously debilitating illness. Depressed persons see their physicians more often than others, and misdiagnosed depression can lead to extensive, expensive diagnostic tests (with obvious implications for health care costs). The most serious consequence of untreated depression is suicide. Major depressive disorders account for up to one-third of all deaths by suicide. While men in the U.S. commit suicide four times as often as women, women attempt suicide four times as often as men.

Time does not permit a more detailed discussion of gender-based differences in the prevalence, course and treatment of mental disorders in women. I hope this brief summary helps frame the questions before you today: *What do we know about post-pregnancy depression?* and *What can we do about it?*

The Importance of the Diagnostic and Statistical Manual of Mental Disorders (DSM):

Psychiatrists and other mental health professionals depend on accurate diagnostic tools to help them identify precisely the mental illnesses their patients suffer, an essential step in deciding what treatment or combination of treatments the patient needs. The Diagnostic and Statistical Manual of Mental Disorders (or DSM) has become a central part of this process. DSM is, simply, the internationally-recognized standard for the diagnosis of mental disorders. As such, it provides the most comprehensive diagnostic framework for defining and describing mental disorders. DSM-IV is embodied in over 650 state and federal statutes and regulations.

The DSM-IV is based on decades of research and was developed through an open process involving more than 1,000 national and international researchers and clinicians drawn from a wide range of mental and general health fields. The special 27-member DSM-IV Task Force worked for five years to develop the manual in a process that involved 13 work groups, each of which focused on a section of the manual. I myself was a member of the work group addressing late luteal phase dysphoric disorder, or premenstrual dysphoric disorder, as it came to be known. The work groups and each of their advisory groups of 50 to 100 individuals developed the manual in a three-step process.

The first step in the three-stage empirical review was the development of 150 reviews of the scientific literature, which provided the empirical database upon which DSM-IV decisions could be made. In the second step, task force work groups reanalyzed 50 separate sets of data which provided additional scientific information to that available in the published literature. Finally, the task force conducted 12 field trials with funding from the National Institute of Mental Health, National Institute on Drug Abuse, and the National Institution of Alcoholism and Alcohol Abuse, in-

volving more than 88 sites in the United States and internationally and evaluations of more than 7,000 patients. As you can see, the DSM-IV is based on systematic, empirical studies.

The DSM-IV's codes are in agreement with the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). ICD-9-CM is based on the ICD-9, a publication of the World Health Organization, used worldwide to aid in consistent medical diagnoses.

The DSM-IV's codes often are required by insurance companies when psychiatrists, other physicians and other mental health professionals file claims. Even the Centers for Medicare and Medicaid Services (CMS) require mental health care professionals to use the DSM codes for the purposes of Medicare reimbursement.

DSM and Depression and Psychosis:

One of the more unfortunate aspects of our culture is that we tend to toss around diagnostic criteria in commonplace language. We say, for example, that a student who gets a "C" on a mid-term is "depressed," or that someone who is acting in an agitated way is "psychotic." Doing so underscores the lack of understanding and the stigmatic way in which we approach serious illnesses that happen to be mental illnesses. For purposes of today's hearing it may be useful to briefly discuss depression and psychosis in the context of the DSM.

Depression: When used to describe a mood, the word "depression" refers to feelings of sadness, despair, and discouragement. As such, depression may be a normal state of feelings which any person could experience from time to time. "Depression" is also a clinical and scientific term, and in these contexts may refer to a "symptom" seen in a variety of mental or physical disorders, or it may refer to a "mental disorder" itself. DSM-IV classifies depression by severity, recurrence, and association with mania.

Psychosis: Psychosis is part of a severe mental disorder and is characterized by a person's gross impairment in perceiving reality. A psychotic person may be delusional or may experience hallucinations, disorganized speech, or disorganized or catatonic behavior. Psychosis may show up, for example, in patients who are suffering from schizophrenia, delusional disorders, and some mood disorders including manic-depression or bipolar disorder.

Postpartum Psychiatric Disorders:

I was asked to focus most of my testimony on the question of post-abortion depression and psychosis, which I will do. Although others have addressed postpartum disorders, let me briefly talk about them. Mental disorders following childbirth was first mentioned over 400 years before the birth of Christ, by Hippocrates, who described the case of a woman in Cyzicus who "gave birth with difficult labor," became sleepless and wandered at night, eventually suffering great distress before becoming rational again.

Today we know from research that disturbances can occur in the postpartum period in the form of "baby blues," or more seriously as postnatal depression or psychosis. Onset of baby blues occurs within days of delivery and can impact a significant number (some suggest 28 to 80 percent) of mothers across cultures. Features include emotional lability unrelated to past history, but the disorder is self-limited. Women with baby blues benefit from reassurance that the symptoms are common and will quickly disappear, but should be advised to seek help if symptoms are severe or persist for more than two weeks.

Postpartum depression is an affective disorder lasting more than two weeks, typically with an onset beginning two to four weeks postpartum, the severity of which meets criteria for DSM-IV designation. Special attention to postpartum depression is warranted because—in addition to the impact on maternal health and mental health—it increases the risk of negative parenting behaviors and puts children at risk for adverse outcomes in social, emotional, and behavioral development. Many cases are missed because new mothers are discharged so quickly from the hospital, and thereafter most care is provided by physicians focused on the care and wellness of the infant. The literature shows risk factors including a previous history of depression, particularly depression occurring antepartum.

Postpartum psychoses are psychotic disorders arising after childbirth. These are acute, severe illnesses occurring after one or two of every 1,000 births. Symptoms include mood lability, severe agitation, confusion, thought disorganization, hallucinations and sleeplessness. Most researchers believe that postpartum psychosis is a manifestation of bipolar disorder. These episodes of psychotic illness are triggered by the biologic and psychological stresses of pregnancy and delivery. The results of misdiagnosed psychosis occurring postpartum or lack of access to effective treatment can be, frankly, horrific, with some mothers committing infanticide followed (in up

to 62 percent of the cases) by suicide. Sadly, several such cases have occurred among Representative Rush's constituents.

One important factor in responding appropriately to postpartum disorders is to call attention to their existence. New mothers need to understand the difference between "the blues" and feelings of overwhelming and persistent sadness. Physicians can help by preparing their patients with some reassuring but straight talk about the fact that childbirth and new parenthood can indeed be stressful and reactions to motherhood can't always be predicted. Peripartum emotional support is important; families should be included in education efforts, assessment of possible risks, and in the provision of supports. In particular, efforts by policymakers to call attention to the problem are most welcome and helpful.

"Post-Abortion Depression and Psychosis:"

Advocates of a created designation of "post-abortion depression and psychosis" typically argue without foundation that abortions can have a long-term impact on the mental health of women who elect to terminate a pregnancy. Alleged symptoms include recurring sadness, persistent feelings of guilt and a host of other factors including eating disorders, substance abuse, suicidal ideation and promiscuity, to name a few.

In fact, the vast majority of women have abortions without psychiatric sequelae, or secondary, consequences. A study of a national sample of more than 5,000 women in the U.S. followed for eight years concluded that the experience of abortion did not have an independent relationship to women's well-being.

The most powerful predictor of a woman's mental state after an abortion is her mental state before the abortion. The psychological outcome of abortion is optimized when women are able to make decisions on the basis of their own values, beliefs and circumstances, free from pressure or coercion, and to have those decisions, whether to terminate or continue a pregnancy, supported by their families, friends and society in general.

As a practicing psychiatrist, I have seen a 15-year-old girl who was pregnant as a result of being raped by a family friend, her grades falling and depression descending as she and her mother sought funds to pay for an abortion to avoid compounding the trauma of the assault. I have seen a young woman who had an abortion in her teens without support from family or friends, and who did not have the opportunity to talk about her feelings until entering psychotherapy for other reasons later in her life. There, she concluded that the decision had been painful but correct and went on to have and cherish several healthy children. I worked with a woman who had an abortion early in her life and had to come to grips, decades later, with the fact that she might never have a child, and in the process, reaffirmed that she had made the right decision when she was younger.

My professional experience reflects the scientific findings: women do best when they can decide for themselves whether to take on the responsibility of motherhood at a particular time, and when their decisions are supported. No one can make the decision better than the woman concerned. Mental illnesses can increase the risk of unwanted pregnancy, but again, abortion does not cause mental illness.

President Ronald Reagan appointed C. Everett Koop, M.D., as the Surgeon General of the United States and asked him to produce a report on the effects of abortion on women in America. Dr. Koop was known to be opposed to abortion, but he insisted upon hearing from experts on all sides of the issue. The American Psychiatric Association assigned me to present the psychiatric data to Dr. Koop. I reviewed the literature and gave my testimony. Later, I went on to publish two books and a number of articles based upon the scientific literature.

Dr. Koop, though personally opposed to abortion, testified that "the psychological effects of abortion are miniscule from a public health perspective." It is the public health perspective which with we are concerned in this hearing, and Dr. Koop's conclusion still holds true today.

Despite the challenges inherent in studying a medical procedure about which randomized clinical trials cannot be performed, and despite the powerful and varying effects of the social milieu on psychological state, the data from the most rigorous, objective studies are clear: abortions are not a significant cause of mental illness.

I am submitting for the record under separate cover some of the excellent scientific articles, published in the world's most prestigious medical journals, upon which I base my professional conclusions. These articles speak for themselves.

The fact that there is no psychiatric syndrome following abortion, and that the vast majority of women suffer no ill effects, does not mean that there are no women who are deeply distressed about having had abortions. Some are members of communities that strongly disapproved of abortion and some were unaware of or unable to access other options. It was difficult in the past for some of these women to dis-

cuss their negative feelings. Some are now actively organized to affirm and underscore those feelings and to publish and publicize their accounts. These accounts, however, are not scientific studies, which cannot rely on self-selected populations, or those specifically recruited because of negative feelings.

It's important to understand that an unwanted pregnancy is a major stressor in a woman's life. According to Burt and Hendrick, research suggests that for women "who have undergone an elective first-trimester abortion, the strongest predictor of poor postabortion psychological outcome is a prepregnancy history of depression." Other factors can include medical or genetic factors (that is, that the pregnancy is terminated because of medical or genetic risks or complications), and a feeling that the decision to abort was not freely made. Again, the literature shows that freely chosen abortion does not result in postabortion psychopathology. Notably, in an article published in 2000 in the Archives of General Psychiatry assessing the psychological consequences of first-trimester abortions, the rate of reported posttraumatic stress disorder in the subjects was lower than the rate in a general female population matched by age.

Some articles and statements aimed at the public have gone so far as to claim the existence of an "abortion trauma syndrome." We are all familiar with posttraumatic stress disorder, or PTSD, a condition tragically brought to public attention by the horrific events of September 11, 2001. "Abortion trauma syndrome" does not exist in the psychiatric literature and is not recognized as a psychiatric diagnosis.

Let me make a few specific observations about many of the primary arguments put forward by some who support the nomenclature of "post abortion depression" and "post abortion psychosis."

• The terms confuse emotions with psychiatric illnesses. As stated earlier, the term "depression" can be used for both a passing mood and a disease. Sadness, grief and regret follow some abortions, for very understandable reasons. These are not diseases. There is no evidence that women regret deciding to have abortions more than they regret making other decisions, including having and raising children, or allowing their babies to be adopted by others. We have a 50 percent divorce rate in this country. One might conclude that many or most of those 50 percent regret having gotten married, but as a nation, we are working to promote marriage, not to make it difficult.

• Supporters of the would-be created nomenclature do not distinguish women who terminate unwanted pregnancies from those who have to terminate wanted pregnancies because of threats to their own health or serious malformations in their fetuses. Those circumstances can cause terrible disappointment, a sense of failure, and concern over the possibility of future pregnancies, all of which are stressors independent of the abortion itself.

• The arguments overlook an obvious reality: only pregnant women have abortions. They fail to compare the aftereffects of abortion with the aftereffects of pregnancy, labor, and childbirth. Full-term pregnancy is associated with considerably greater medical and psychiatric risk than is abortion. The incidence of psychiatric illness after abortion is the same or less than after birth. One study reports that for each 1,000 women in the population, 1.7 were admitted to a psychiatric inpatient unit for psychosis after childbirth, and 0.3 were admitted after an abortion.

• Assertions that abortion causes mental illness do not take into account the reasons women become pregnant when not intending to have babies, and the reasons pregnant women decide to have abortions. Pre-existing depression and other mental illnesses can make it more difficult for women to obtain and use contraception, to refuse sex with exploitative or abusive partners, and to insist that sexual partners use condoms. Poverty, past and current abuse, incest, rape, lack of education, abandonment by partners, and other ongoing overwhelming responsibilities are in themselves stressors that increase the risk of mental illness and increase the risk of unintended pregnancy.

• Likewise, they do not account for the mental health of the woman before she has an abortion. Pre-existing mental state is the single most powerful predictor of post-abortion mental state. As we all learned in school, association does not mean causation. Having a serious mental illness at a given time may make some women decide that it would not be appropriate to become mothers at that time. The scientific literature indicates that the best mental health outcomes prevail when women can make their own decisions and receive support from loved ones and society whether they decide to continue or terminate a pregnancy.

• Some articles I have seen assume that all women who have abortions require mental health intervention. There is no evidence that women seeking abortions need counseling or psychological help any more than people facing other medical procedures. Standard medical practice demands that patients be informed of the nature

of a proposed medical procedure, including its risks, benefits and alternatives, and that they be allowed to make their own decisions. Of course this applies to abortion as well. Because the circumstances and decision can be stressful, most facilities where abortions are performed make formal counseling a routine part of patient care.

• Over 30 percent of women in the United States have abortions at some time in their lives, and very few of these seek or need psychiatric help related to the procedure—either before or after. Our role, as mental health professionals, when patients do seek our consultation under those circumstances, is to help each patient review her own experiences, situation, plan, values, and beliefs, and make her own decision.

• There is little attempt made to address the impact of barriers to abortion, social pressure, and misinformation on the mental health of women who have abortions. Imagine being in a social milieu where your pregnancy is stigmatized and abortion is frowned upon, having to make excuses for your absence from home, work, or school, travel a great distance to have the procedure, endure a waiting period, perhaps without funds for food or shelter. Imagine having to face and go through a crowd of demonstrators in order to enter a medical facility. Finally, imagine being told that the medical procedure you are about to undergo is very likely to cause mental and physical health problems "although this is not true. Any stress or trauma caused by these external factors should not be confused with reactions to the abortion itself.

• With respect to parental consent issues, one important study involved adolescents who had negative pregnancy tests with those who were pregnant and carried to term and those who were pregnant and had terminated the pregnancy. All three groups had higher levels of anxiety than they showed one or two years later. But, the interesting result was that two years later, the adolescents who had abortions had better life outcomes—including school, income, and mental health—and had a significantly more positive psychological profile, meaning lower anxiety, higher self-esteem and a greater sense of internal control than those who delivered and those were not pregnant. As all of us support planned pregnancies and parenthood and healthy families, we need to better understand and respond to issues such as postpartum and maternal-/parenting-related depression so that women who continue their pregnancies are not at greater risk.

• With respect to health issues, there is much misinformation about medical sequelae of abortion. Breast cancer is a good example. But here's what the National Cancer Institute wrote in its May 2003 report, "Abortion, Miscarriage, and Breast Cancer Risk": "The relationship between induced and spontaneous abortion and breast cancer risk has been the subject of extensive research beginning in the late 1950s. Until the mid-1990s, the evidence was inconsistent . . . Since then, better-designed studies have been conducted. These newer studies examined large numbers of women, collected data before breast cancer was found, and gathered medical history information from medical records rather than simply from self-reports, thereby generating more reliable findings. The new studies consistently showed no association between induced and spontaneous abortions and breast cancer risk."

The most highly regarded and methodologically sound study on the purported link between abortion and breast cancer—Melbye's "Induced Abortion and the Risk of Breast Cancer," which appeared in the New England Journal of Medicine in 1997—indicates that there is no relationship between induced abortion and breast cancer. In contrast with most of the studies in this area, this study contains a large study sample (1.5 million women) and relies on actual medical records rather than women's recollection, which can be influenced by fear and the attitudes of their communities.

In February 2003, the National Cancer Institute, a part of the U.S. Department of Health and Human Services, brought together more than 100 of the world's leading experts on pregnancy and breast cancer risk. Workshop participants reviewed existing population-based, clinical, and animal studies on the relationship between pregnancy and breast cancer risk, which included studies of induced and spontaneous abortions. This workshop "concluded that having an abortion does not increase a woman's subsequent risk of developing breast cancer." The World Health Organization, which conducted its own review of the subject, came to the same conclusion.

In plain language, there is no medical basis for the claim that abortion increases the risk of breast cancer. This position, shared by the National Cancer Institute and the American Cancer Society, is based on a thorough review of the relevant body of research. Among studies that show abortion to be associated with a higher incidence of breast cancer, most are unreliable due to recall bias and other methodological flaws. By contrast, studies that were designed to avoid such biases show no

relationship. It is irresponsible for politicians to develop public policy that is based upon false medical allegations.

Conclusion:

Mr. Chairman, as a woman, as a physician, and particularly as a psychiatrist, I have great sympathy and compassion for all of my patients, women and men, adults and adolescents, who struggle with mental illnesses. In order to ensure state of the art treatment, we need to ensure that the scientific process that is the foundation of our reference for diagnostic criteria—the DSM—is maintained at the highest levels. Above all else, what the women I treat need is access to mental health care.

Today, patients in our great country who seek treatment for mental illnesses all too often find that they lack access to adequate mental health services as a direct result of the discrimination in insurance coverage for mental disorders. If this Congress wants to take one single action that would make a world of difference for all women—for all persons—seeking treatment for mental disorders, I respectfully suggest that the right action would be to enact a federal law requiring non-discriminatory coverage of treatment of mental illnesses as part of all insurance. It is time to end the artificial mind/ body split in insurance coverage. Well over half the House of Representatives and more than two-thirds of the Senate have cosponsored legislation to achieve this result. On behalf of my patients, I respectfully urge you to address the unmet mental health needs of the nation's women, and men, children and adolescents, by enacting non-discriminatory coverage of treatment of mental illnesses.

Thank you again for the opportunity to speak with you today. I would be happy to answer any questions you or other members of the Subcommittee may have.

Mr. PICKERING [presiding]. Thank you, Dr. Stotland.

Mr. Pitts, do you have any questions?

Mr. Brown?

Mr. BROWN. Ms. Blocker, thank you again so much for being here.

Ms. BLOCKER. You are welcome.

Mr. BROWN. Your appearance, obviously, means a lot to all of us, and I'm sure it means a lot to the more than 400,000 women per year who experience depression as a result of childbirth.

Give us, generally, your advice on what this Congress can do, what this committee can do, to help decrease the number of women afflicted with postpartum depression and psychosis each year, and how we can help loved ones better recognize the warning signs before they lead to suicide.

Ms. BLOCKER. Yes, sir.

First of all, I'm going to say that the illness is very insidious. It's very sneaky, and it kind of creeps up on the new mommy before anybody really knows what has happened to her.

Most of the women that have called me, because I have put up a web site for my daughter to help other women, most of the women that call me say their husbands are furious with them, because they want them to snap out of it, and they said they can't snap out of it because, you know, because it's a hormonal thing first of all, and there's nothing they can do to help themselves.

What I would like to see done, what I would like to see done, is more information with the doctors. Every maternity ward should have almost like large warning signs there to warn doctors to look at these new mothers when they come back for their 6-week checkup.

Had I not known Melanie so well, I would have thought that Melanie was just suffering because Melanie has never had any trauma in her life, and believe me, labor pains are awful, and I thought the labor pains had kind of put her in a little deep depres-

sion, or was too traumatic for her. I had no idea that postpartum psychosis even existed.

I would love to see someplace where a woman could go somewhere in America, we have nowhere to treat women. As you can see by these pills that they gave my daughter, they don't know anything about this illness and they are experimenting. They were experimenting with her.

I would like to see some safe haven place for a mother to go and know that she'll be safe until her hormones go back.

Mr. BROWN. Thank you.

Doctor Stotland, talk to us about C. Everett Koop, what his views about abortion are, and what his public stance and reflection on his and other research findings are about this whole issue in Mr. Pitts' bill.

Ms. STOTLAND. When Doctor Koop was selected to be Surgeon General of the United States, he was the editor of the Journal of Fetal Medicine, very much opposed to abortion.

President Reagan ordered him to write a report on the mental and physical effects of abortion on women in the United States, and he undertook to hear from every possible constituency, expert group, advocacy group, et cetera.

And I was, at the time, the Chair of the Committee on Women of the American Psychiatric Association, and my main interest was, in fact, in birth. The President of the American Psychiatric Association said this is your job, you have to do the research on this, and you have to go and present the findings.

And so, I did the research, eventually published a book afterwards, but I remember being very worried, because I knew that he was very personally opposed to abortion, and finally someone said to me 1 day, "It's going to be okay." And, I said, it was an older colleague, and I said, "How can you say that?" And, he said to me, "I went to college with him, and he's an honest man."

So, Doctor Koop heard from absolutely everybody who had something to say or information to bring, and he came out. He refused to write the report, and he came out with a statement I believe he wrote to Congress, anyway to the President, saying what's been quoted here, the psychological impact of abortion on women is minuscule from a public health standpoint, after exhaustively reviewing all the information there was and all the opinions and feelings there were as well.

Mr. BROWN. One other quick question, what are your methodological concerns with Doctor Shadigian's assertions, and articles and reports that she references that abortion causes mental illness?

Ms. STOTLAND. What are my problems with those? I outlined some of them in my testimony, and more are in my written testimony, obviously, but we have to remember why someone has an abortion. The studies that have been published, which are very few and not very well accepted, as opposed to a giant literature about how women do okay after they decide to terminate their pregnancies, is we don't know the baseline. Most of the women who are depressed after abortion were depressed before abortion. We don't know why someone decided to have an abortion, because their mate deserted them and they are upset about that, because they are ter-

ribly poor and they can't afford to have a child because they have many children they are struggling to take care of already, because they know they are too young, because they were raped or coerced into becoming pregnant in the first place, and then you look at what happens afterwards and say, these people were upset. They were upset because of the circumstances, not because of the medical procedure they had.

The vast majority of women come out an abortion feeling relieved, not because they've done something insignificant, but because they've made a responsible, important decision for the benefit often of children they have or want to have in the future, so that they can give them the best possible life.

Mr. PITTS. Mr. Rush.

Mr. RUSH. Thank you, Mr. Chairman.

Ms. Blocker, would you—I understand that Mr. Stokes, Sam Stokes, is a physician, a trained physician.

Ms. BLOCKER. Yes, he's a physician and surgeon.

Mr. PITTS. And surgeon.

Can you share with this committee some of his commentary to you after Melanie's tragic death, in terms of how he was unaware?

Ms. STOTLAND. Yes, it's really sad to say this, but Sam had never heard of the word either, and I had found this book, it was called, "Women's Moods," and I read a little part of it and it said, unfortunately, sometimes new mothers will commit suicide if they have postpartum psychosis, and I gave the book to Sam and I said, "Sam, read this little part here." I said, "It sounds like the symptoms that Melanie had." He said, "You know," they call me Bammy, he said, "You know what, Bammy, Melanie would never kill herself." He said, "She loves life," and he said, "Especially since she's given birth to this little girl that looks just like her." He said, "Bammy, that's preposterous, that's ridiculous," and that's why he left her, and I hate to say it.

I knew my daughter, because Melanie and I were extremely close, and I knew the minute the baby was delivered that something happened during the delivery. I didn't know that a woman's hormones rise extremely high during pregnancy. These are things that we didn't know. I didn't know that during delivery the hormones leave and sometimes, unfortunately, they leave the brain, which is what happened to Melanie. I didn't know that if you took the blood of a woman that was 3 months pregnant and injected it in a man it would damn near kill him. I didn't know that. I had never heard those things before, but now I know.

And Sam didn't know how sick Melanie was. As a matter of fact, a couple times he got angry at her too, and he told her, he said, "You know what, I am really furious that you call yourself having postpartum depression." He said, "when I'm over here at Cook County Hospital working every day," he said, "taking out guts and preparing bodies." He said, "If you want to see a depression, you come over here to Cook County Hospital with me, that will make you really depressed."

He tried a lot of things to try to get her to snap out of it. He said, you know, and I'm going to just say this, he said, "You know, Melanie, I'm going to take Sommer and I'm going to move to Paris and you are never going to see her again if you don't snap out of

this." And, I was there, I heard him say it, and it hurt me, and she said, "See, mommy," she said, "I'm a bad, bad person." She said, "The baby doesn't like me." I said, "The baby is just an infant." She said, "No, mommy, the baby likes you and Sam." She said, "Sam hates me," and she said, "I'm going to have to die."

Mr. PITTS. Doctor Stotland, how widespread is this issue of postpartum psychosis? I know that, you know, we've indicated one in a 1,000 women suffer from it, but those who, in our society, who are suspected of having psychosis and, in fact, rather than killing themselves they may kill a loved one, a child, how does our society deal with them, how does the criminal justice system deal with them right now? What's the tragedy of that?

Ms. STOTLAND. Well, unlike in most other countries of the world, we have no special designation for people who kill their children in the throes of severe mental illness. In other countries that's a separate issue.

As we saw in Houston——

Mr. PITTS. Mr. Chairman, can we suspend just for a moment into the bill?

Mr. PICKERING. Yes, and let me just real quickly say what we are going to do here, as soon as the buzzer stops. We will continue Mr. Rush's questions. When he completes his we will recess. We have two votes. We will come back as quickly as those votes are over, and then we will want to give everybody else a chance to ask their questions.

I would ask that we are sensitive to our time, because we need to get to the second panel as early as possible.

Mr. Rush?

Ms. STOTLAND. As we saw in Houston, as we saw in Texas, Andrea Yates was pretty much treated like a common criminal, like someone who takes out a gun at a convenience store and shoots someone. And, it goes part and parcel with the education that your bill is calling for, because not only does the criminal justice system not understand, people don't understand.

I was on CNN in the course of the Andrea Yates trial, and you know how the little worm runs across the bottom of the screen, and I was offsite, and people were calling in and e-mailing in, and there were literally—and this is the case in the United States right now, just about 50/50, there would be one message that said, nothing is more—no punishment is bad enough for this awful woman. My children aggravate me too, and I didn't kill them. Okay. And then the next message would say, nobody can know what this woman went through unless they went through it. I suffered through this. I was a loving mother, and I suffered through, but luckily I didn't kill my children.

So, we don't have any distinguishing factor in our penal system, in our justice system, to differentiate a criminal who just murders someone from a mother in the throes of horrible delusions and hallucinations, who kills her child.

Mr. RUSH. Thank you, Mr. Chairman.

Mr. PITTS. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

Ms. Blocker, I want to add my sympathy at your loss, and also I want to add, I see a lot of testimony, and this is some of the most

moving and persuasive testimony that we've seen. So, thank you, I know it's hard for you. Ms. Capps and I are mothers too, and we were just sitting here saying——

Ms. BLOCKER. Yes, it's very hard for me, but more than that I am determined to change, to make a change, I'm determined.

Ms. DEGETTE. That's why your testimony is so effective to us.

Ms. BLOCKER. It's not just for Melanie, it's for all women, because honestly men have—they don't have a clue. They don't. And, men are wonderful people, but they do run the world, and I have to say for my daughter she died for this illness. She did.

Ms. DEGETTE. Yes. We are hoping to change that.

Ms. BLOCKER. I hope so.

Ms. DEGETTE. Doctor Stotland, I wanted to ask you a couple of questions.

You talked about Surgeon General Koop's extensive research and conclusions. I'm wondering if you could talk to me about any other research on the so-called post-abortion depression issue that's been done since Doctor Koop's.

Ms. STOTLAND. Well, the psychiatric impact of abortion has been continued to be studied intensively, not with the name of a diagnosis that doesn't exist, but has been studied, and there's been an article in Science, which is probably the most prestigious, difficult to get into, journal in the world, about scientific matters, again, demonstrating that abortion does not cause psychiatric illness.

I think I've alluded to some of the small literature that purports to demonstrate psychiatric problems after abortion, and some of the severe methodologic problems with it, not having a baseline, not knowing what circumstances the woman was in, whether she was coerced, whether she was raped, et cetera.

Ms. DEGETTE. Are you aware of the research of Doctor Shadigian, who will testify on the next panel?

Ms. STOTLAND. I'm sorry, I got distracted by the buzzer.

Ms. DEGETTE. Are you aware of the research of Doctor Shadigian, who is scheduled to testify on the next panel?

Ms. STOTLAND. Yes, Doctor Shadigian and I have both testified in the Senate on a similar bill, and she and I have both reviewed the literature. Neither of us is actually in the trenches doing the research, we are the ones keeping track of the research.

Ms. DEGETTE. So, her research is not original research, it's based on a review of existing research, as is yours?

Ms. STOTLAND. That's my understanding, yes.

Ms. DEGETTE. Now, the studies that form a basis for her testimony, that assert a connection between abortion and depression, do they control for the patient's previous mental state?

Ms. STOTLAND. No, they don't.

Ms. DEGETTE. How important is that in a study?

Ms. STOTLAND. It's the most important determining factor in the outcome.

Ms. DEGETTE. Why is that?

Ms. STOTLAND. It just is, because this procedure doesn't change someone's psychiatric condition.

Ms. DEGETTE. Now, in her brief testimony that was submitted to the panel, Doctor Shadigian mentions that women who choose

abortions are more likely to be victims of violent crime, especially homicides.

How do you respond to that assertion?

Ms. STOTLAND. Well, there's a new study in JAMA that came out quite recently, demonstrating that the No. 1 killer of pregnant women is homicide. Okay? So, we have to always compare abortion with having a baby, or continuing a pregnancy.

So again, people who choose to have abortions, and as was indicated, after careful thought, okay, are people who have been in difficult circumstances. They were people who were subject to abuse before, they are subject to abuse afterwards.

Ms. DEGETTE. So, one might expect to find similar rates for people who carried the baby to term or had abortions, it's not related to whether they terminated the pregnancy or had the baby, it's related to their pre-existing circumstances.

Ms. STOTLAND. Correct.

Ms. DEGETTE. Now——

Ms. STOTLAND. By the way, we've submitted a great deal of scientific literature for the committee today.

Ms. DEGETTE. Mr. Chairman, I'd ask that that literature be included. I'd ask for unanimous consent that be included.

Mr. PITTS. Is there any objection?

Hearing none, so ordered.

Ms. DEGETTE. I just have one last question. There's a study that you mentioned in your written testimony that found for each 1,000 women in the population, 1.7 were admitted to a psychiatric in-patient unit for psychosis after child birth, and .3 percent were admitted after abortion. Can you talk to me about that study, the sample size, any contrary evidence that may have been published?

Ms. STOTLAND. Sure. It's a little bit technical, that study is fairly old. It's very hard, as we've all been arguing here today, for better access to mental health care, it's very hard to get to a hospital at all today, and that's something of what Melanie went through as well, obviously, just having to leave the hospital without being all well yet. But again, it demonstrates that if you are going to talk about the condition people are in after they have a baby, or after they have an abortion, they are at considerably greater risk of having severe mental illness after having a baby, unfortunately, than after having an abortion.

Ms. DEGETTE. Thank you.

Thank you very much, Mr. Chairman.

Mr. PITTS. Thank you.

I believe that we have time for one more set of questions for 5 minutes. We now have 6 minutes and 24 seconds left in a vote.

You don't think—all right, we'll recess, we always try to be efficient around here.

Ms. Blocker, I would like to say how much I appreciate your courageous testimony, your story, and the powerful experience, and this Congress has many examples of where personal stories like yours has affected decisions, and laws, and policies, and we hope that that's the outcome of this hearing.

Thank you, Ms. Blocker.

Ms. BLOCKER. Thank you.

[Brief recess.]

Mr. BILIRAKIS. The hearing is called to order, the Chair apologizes to the witnesses, this is our life up here, though, back and forth.

In any case, the Chair recognizes Mr. Towns to inquire.

Mr. TOWNS. Thank you very much, Mr. Chairman.

What can we do, Doctor Stotland, to encourage a team approach in terms of getting the OB/GYN folks involved, psychologists, social workers, psychiatrists, and all of them, to see what we can do to overcome this barrier?

Ms. STOTLAND. Well, luckily ACOG, the American College of Obstetricians and Gynecologists, has taken this quite seriously, as have the other organizations.

Obviously, we need more support. If people can't get the mental health care after the diagnosis is made, then it doesn't do any good, then we just have people with a diagnosis and no treatment. So, we need to, as has been mentioned, eliminate the insurance barriers and the terrible things that are happening to funding in the states as well for mental health services.

And also, there's some things we really need to understand better. We know that postpartum depression and psychosis exists, we can treat them, usually quite successfully. We know very little about prevention, and that team that you mentioned could very well come together and there is some new research, just brand new, and a very exciting area of research, that's what we really need to do, is prevent this terrible thing from happening. A team approach is perfect.

Mr. TOWNS. If we start in terms of adolescence, is there anything you think we might be able to do there to prevent this from happening later on in life?

Ms. STOTLAND. Well, that's what we don't know. We know that some young women are more—some women are more vulnerable to times of hormonal change than others. Some have PMS worse than others, can't take birth control pills, and then they may be the ones who have trouble postpartum when there's a big change in hormones.

But, that would be very interesting research to do, but I don't know of any—I don't know of any way that we could do that. I think right now what we want to do is start with the woman when she gets pregnant, in terms of postpartum depression, and see, especially, the ones we know are vulnerable already, including the young ones, and then jump in and see what we can do to prevent it.

We know now we can jump on it the minute after the woman delivers and try and—if we were anticipating it, like someone who had it before for example, or has had depression before, and we can start treating that woman the minute she delivers. But, to prevent it from ever happening in the first place while she's still pregnant, we don't know how.

Mr. TOWNS. Well, let me thank both of you for your testimony, I really think that you've provided a great service here for us in the Congress. I want to just thank you very much.

I also want to thank you, Ms. Blocker, for your commitment and your dedication to get the word out, because I can imagine the pain and the suffering that you have gone through. So again, we salute

you and hope you continue, because it's a story that needs to be told. More people need to know about it.

Thank you so much.

Ms. BLOCKER. Thank you.

Ms. STOTLAND. Thank you.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Ms. Capps to inquire.

Ms. CAPPS. Thank you, Mr. Chairman, and again, thank you to this amazing first panel.

Ms. Blocker, you have done a beautiful thing, and are in the process of really paying the finest tribute to your daughter's life, as she lived it so richly when she was here on earth, and I commend you for your bravery and your ability to focus your grieving and your utter sadness into something that is so positive, as judged from what you've compiled on your web site, and so much is indicated by the testimony that you gave, very eloquent, very moving. And, I am one who is committed in her name to passing this legislation that you and—both of you have such a fine representative here on our subcommittee.

And, since you nodded when I mentioned Jane Honiquan's name, I'll be happy to let her know. I believe those who have experience postpartum depression, or have a loved one who has, are such marvelous advocates and really so important in moving us forward on this, so I want to commend you for that, and also to thank you, Doctor Stotland, for your common sense approach to this topic, which needs the expertise that you can bring to it, and I thank you for your continued interest, and I know you've had to spend a lot of time in front of panels and on the circuit, if you will, but it's part of what's needed now to raise the awareness about a mental health condition that can be treated and that with the kind of interest that we should do can be prevented as well.

I want to ask you a question about statements that I've heard floating around, and, perhaps, maybe we'll hear in the next panel, that some have equated feelings of sadness following an abortion with post-traumatic stress syndrome or PTSD, which I believe is a defined disorder in which exposure to exceptional mental or physical stress is followed by persistent re-experiencing, flashbacks if you will, of that event.

And, I wonder, I know it's a battlefield term that we're now quite familiar with, and has been well documented, is that an accurate comparison for post-abortion trauma?

Ms. STOTLAND. Well, let me say several things. PTSD is a real psychiatric disorder.

You spoke about veterans, we now know that it's more common in women and children than it is in men. There is no literature to indicate that abortion overall is associated with post-traumatic states of any kind.

That isn't to say that an individual woman couldn't be under horrible circumstances, have to go through a crowd of people screaming and yelling, have to go to another State and not have enough money to wait the waiting period, be forced into an abortion because her husband says I'll leave you if we have another baby, that there can't be other circumstances surrounding an abortion. And certainly before they were legal, and people were not given anes-

thesia, and, you know, were in a back alley, one can readily imagine that that could have been—amounted to the level of trauma.

Ms. CAPPS. So, in other words, if we are going to do studies on post-abortion situations, we can't do that without really understanding the pre-existing conditions.

Ms. STOTLAND. Absolutely, and we already know that if we make the circumstances less traumatic then the likelihood of post-traumatic stress disorder happening would be much less. Again, there's no recognized form of PTSD or relationship between PTSD and abortion.

Ms. CAPPS. Since this is our one chance to talk about what we could do, Mr. Towns gave you this opportunity, but I wanted to just see if there's something more you wanted to say. It's at a time of limited fiscal opportunities, the pressures are great upon us here in Congress in terms of appropriating funds. I believe strongly, as you do, in the Wellstone and Domenici mental health parity, but how can you give this panel a bit more of your incite and expertise as to how we could best prioritize funds that would be-should be allotted in a way that would improve women's mental health in general?

Ms. STOTLAND. Well, let me continue for a moment with the postpartum issue.

Ms. CAPPS. Sure.

Ms. STOTLAND. Although I said very honestly that we don't have the data yet about primary prevention, this is a disorder that affects the whole family.

When I heard Ms. Blocker, she and I have presented together once before, and in that, that was in a Congressional Black Caucus, and I will never forget the sight of Melanie's bereaved widower husband, okay. What that left him with after going through this, we heard how he didn't understand, okay, and we know that it has measurable effects on the baby, the mother is depressed.

So, if there is anywhere you are going to put money, in terms of affecting a whole family, affecting a whole society, I mean look what the stress on Ms. Blocker, on her sister, et cetera, et cetera. It seems to me if we are going to single out any disorder this is a very smart disorder to single out, and, of course, we want to make treatment available to everybody. People who do have trouble around the time of an abortion, people for whom it is a very upsetting circumstance, should be able to go and get care, you know, just as women who have trouble after having a baby. There doesn't have to be a disease made up for people who happen to be depressed, and were depressed before quite likely, to get care.

Ms. CAPPS. I wish we had more time, but thank you very much.

Mr. BILIRAKIS. I thank Doctor Stotland, Ms. Blocker, I do believe—Mr. Pitts, do you have anything further? I think that completes the questioning of this panel.

You know, I know the interruptions hurt, hurt your communication and what not, but what can we do, that's our life up here.

But, we really appreciate your taking time to come here, and, Ms. Blocker, again, what can we say? If there's any good at all in what happened, it is helping you to communicate to us and to the world, that this is really a very serious real world problem. So, thank you so very much.

Ms. BLOCKER. Thank you, and I do want to state that I love my daughter with all of my heart.

Mr. BILIRAKIS. I bet you did.

Thank you. Well, you are showing that.

Ms. BLOCKER. Thank you.

Mr. BILIRAKIS. The second panel, let's see, it's Michaelene Fredenburg, President of the Life Resource Network from San Diego, California, you have come a long way, and Doctor Elizabeth Shadigian, Clinical Associate Professor with the Department of OB/GYN, as we say, Obstetrics and Gynecology, Ann Arbor, Michigan, University of Michigan. When you say Ann Arbor we assume it's the University of Michigan, don't we?

We appreciate your coming here. Again, your written statement is a part of the record, and we would hope that you will complement it in some way. I'll set the clock at 5 minutes.

And, Ms. Fredenburg, again, I said it earlier, thanks so much for your courage. I know it's going to be helpful to share that with us.

Would you proceed, please?

STATEMENTS OF MICHAELENE FREDENBURG, PRESIDENT, LIFE RESOURCE NETWORK; AND ELIZABETH SHADIGIAN, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, MOTT HOSPITAL

Ms. FREDENBURG. Mr. Chairman, good afternoon. My name is Michaelene Fredenburg. I'm President of the Life Resource Network, and I do live in San Diego, California, and I do want to thank you for the opportunity to testify before this committee today.

Women's rights and human rights have always been a passion of mine. As a teenager, I assumed that legalized abortion was necessary for women, so it's not surprising that when I became pregnant at 18 I thought about having an abortion. I also considered adoption, but when I told my boyfriend he said he'd kick me out if I didn't have an abortion.

I turned to my employer for advice. She agreed that abortion was the only logical option and offered to arrange one for me.

My experience at the abortion clinic was painful and humiliating. I met briefly with a counselor who characterized my 8-week pregnancy as "a couple of cells" and the "products of conception." When the abortion provider entered my procedure room, I began to have second thoughts and asked her assistant if I could have a few minutes. The doctor yelled, "Shut her up," and started the suction machine. It was not an empowering experience. I felt violated and betrayed.

I was also completely unprepared for the emotional fallout after the abortion. I soon found myself in a cycle of self-destructive behavior that included an eating disorder.

Desperate for a fresh start, I broke up with my boyfriend, quit my job, and moved from Minnesota to Hawaii. While living in Hawaii, I was shocked to learn that an 8-week embryo is at least a ½ inch long with a head, arms and legs, a beating heart and functioning brain. I sank even deeper into depression and self-hatred as I realized that I had destroyed my child. I would experience periods of intense anger, followed by periods of profound sadness.

For weeks and sometimes months at a time I was too fatigued to do more than eat a meal and shower during the day. I lost interest in food, and my weight fell dangerously low. There were also periods when I seemed to be able to pull myself together.

I saw a number of doctors for the fatigue and weight loss. They tested me for everything from lupus, to cancer, to AIDS. I did not tell them about the feelings I was having as a result of the abortion, because I did not see a connection between the abortion and my physical symptoms.

This continued for the next few years until suicidal thoughts began to scare me. This is when I finally went to see a therapist. With the help of counselors and supportive friends the time of self-condemnation and self-punishment came to an end.

In addition to grieving the loss of my child, I suddenly became aware the impact my choice had on other members of my family. My parents believe that somehow they failed me and that they are partly responsible for the death of their grandchild. When I first told my sister she cried and said she wished she didn't know. My oldest son found out quite young, and he still struggles with the loss of a sibling and the reality that his mother was the cause of the loss. My youngest son, who is nine, hasn't been told yet, and it breaks my heart that he will have to deal with the loss that I inflicted.

In addition to coping with the fallout the abortion has caused to my family, there are still times that are painful for me. After all, healing doesn't mean forgetting. The year that my child would have graduated from high school was very difficult. My best friend's daughter was graduating that year, and each time she talked about senior activities I was reminded that my child would not be participating. I agonized for weeks after I received an invitation to attend the graduation. In the end, I had to decline. I didn't want to spoil her celebration with my sorrow.

At one time I thought that my abortion experience was unique, but over the years I have found that it is not. There is mounting evidence, both anecdotal and in published studies, that women suffer emotionally after an abortion, but since abortion is held hostage to politics and special interest groups there are too few reliable studies that have been done. Abortion continues to be an unchecked and unstudied experiment on American women.

It's normal to grieve after a pregnancy loss, whether the loss is caused by a miscarriage, still birth, adoption, infertility or an abortion. Most of us know someone who has suffered a loss of a child through miscarriage. The loss in an abortion is similar except for two important factors. The woman opted for the abortion, many times succumbing to pressure from others, and the abortion is often done in secret.

An important part of grieving is talking. Since an abortion is typically a secret, the woman is unable to talk. Even when she is able to talk about the abortion experience, her efforts are often met with resistance. Her partner typically doesn't want to discuss it. Well-meaning family and friends may try to help her by encouraging her to move on with her life and forget about the abortion. She may fear that pro-life individuals will condemn her and pro-choice individuals deny her feelings. With no safe place to deal

with her emotions, she may need to repress or numb them in order to cope. This repressed grief can lead to prolonged feelings of sadness, nightmares, loss of self-esteem, eating disorders, substance abuse, destructive relationships, an inability to bond with future children, or even attempted and completed suicides.

If the abortion's loss is followed by additional pregnancy losses, such as miscarriage or infertility, the multiple losses will only increase the inner chaos and pain.

Although much has changed in the 19 years since my abortion, not much has changed for women experiencing an untimely pregnancy. They undergo abortion, not so much out of choice, but as a desperation or as a last resort. I believe women deserve better than this.

Although some women are able to move on from their abortion, many are left with physical or emotional scars that negatively affect their lives for years and sometimes decades.

In all the noise surrounding abortion, women are often forgotten. It's time to stop the noise and start listening to women who have experienced abortion and other pregnancy losses.

I'm grateful that you've taken the time to listen, and I urge you to continue to take steps to understand the impacts abortion and other pregnancy losses have on women.

Thank you.

[The prepared statement of Michaelene Fredenburg follows:]

PREPARED STATEMENT OF MICHAELENE FREDENBURG, PRESIDENT, LIFE RESOURCE NETWORK

Mr. Chairman, good afternoon; my name is Michaelene Fredenburg, I am President of the Life Resource Network, and I live in San Diego, California. I thank you for the opportunity to testify before this Committee today.

Women's issues, women's rights and human rights have always been a passion of mine. As a teenager I assumed that legalized abortion was necessary for women to attain their educational and career goals. So, it's not surprising that when I became pregnant at 18 I thought about having an abortion. I also considered adoption, but when I told my boyfriend, he said he would kick me out if I didn't have an abortion. I turned to my employer for advice. She agreed that abortion was the only logical option and offered to arrange one for me.

My experience at the abortion clinic was painful and humiliating. Although the young women awaiting their abortions were anxious and tearful, the clinic staff was cold and aloof. I met briefly with a "counselor" who characterized my 8-week pregnancy as a "couple of cells" and the "products of conception."

When the abortion provider entered my procedure room, I began to have second thoughts and asked her assistant if I could have a few minutes. The doctor yelled "shut her up" and started the suction machine. It was not an empowering experience. I felt violated and betrayed.

I was also completely unprepared for the emotional fallout after the abortion.

I soon found myself in a cycle of self-destructive behavior that included an eating disorder. Desperate for a fresh start, I broke up with my boyfriend, quit my job, and moved from Minnesota to Hawaii.

While living in Hawaii I educated myself about fetal development. I was shocked to learn that an 8-week embryo is at least a half-inch long with a head, arms and legs, a beating heart and functioning brain. I sank even deeper into depression and self-hatred as I realized that I had destroyed my own child.

I would experience periods of intense anger followed by periods of profound sadness. For weeks and sometimes months at a time I was too fatigued to do more than eat a meal and shower during the day. I lost interest in food and my weight fell dangerously low. There were also periods when I seemed to be able to pull myself together and at least outwardly lead a normal life.

I saw a number of doctors for the fatigue and weight loss. They tested me for everything from lupus to cancer to AIDS. I did not tell them about the feelings I was having as a result of the abortion because I did not see a connection between the

abortion and my physical symptoms. This continued for the next few years until suicidal thoughts began to scare me. That is when I finally went to see a therapist.

With the help of counselors and supportive friends the time of self-condemnation and self-punishment came to an end allowing me to enter into a healthy grieving process. In addition to grieving the loss of my child, I slowly became aware of the impact my choice had on other members of my family.

Although I have repeatedly assured my parents that I never doubted their support and assistance if I had decided to carry the baby to term, they continue to believe that somehow they failed me and that they are partly responsible for the death of their grandchild. When I first told my sister she cried and said she wished she didn't know about the niece or nephew that is missing. My oldest son found out quite young and still struggles with the loss of a sibling and the reality that his mother was the cause of the loss. My youngest son who is 9 hasn't been told yet, and it breaks my heart that he will have to deal with a loss that I inflicted.

In addition to coping with the fallout the abortion has caused in my family there are still times that are painful for me. After all, healing doesn't mean forgetting. Mother's Day is particularly difficult. The year that my child would have graduated from high school was also filled with pain. My best friend's daughter was graduating that year and each time she talked about Senior activities I was reminded that my child would not be participating. I agonized for weeks after I received an invitation to attend the graduation ceremony. I wanted so badly to attend and show my support, but in the end I had to decline. I didn't want to spoil her celebration with my sorrow.

At one time I thought that my abortion experience was unique, but over the years I have found that it is not. There is mounting evidence—both anecdotal and in published studies—that women suffer emotionally after an abortion. But since abortion is held hostage to politics and special interest groups there are too few reliable studies that have been done. Abortion continues to be an unchecked and unstudied experiment on American women.

It is normal to grieve after a pregnancy loss whether the loss is caused by a miscarriage, stillbirth, adoption, infertility or an abortion. Most of us know someone who has suffered the loss of a child through miscarriage. The loss in an abortion is similar except for two important factors: the woman opted for the abortion, many times succumbing to pressure from others, and the abortion is often done in secret. An important part of grieving is talking. Since an abortion is typically a secret, the woman is unable to talk about it.

Even when she does want to talk about the abortion experience, her efforts are often met with resistance. Her partner typically doesn't want to talk about it. Well-meaning family and friends may try to "help" her by encouraging her to move on with her life and forget about the abortion. She may fear that pro-life individuals will condemn her and pro-choice individuals deny her feelings. With no safe place to deal with her emotions, she may need to repress or numb them in order to cope.

This repressed grief can lead to prolonged feelings of sadness, nightmares, loss of self-esteem, eating disorders, substance abuse, destructive relationships, an inability to bond with future children or even attempted and completed suicides. A woman suffering from a past abortion often feels isolated—as if she is the only one feeling this way. If the abortion loss is followed by additional pregnancies losses such as a miscarriage or infertility, the multiple losses will only increase the inner chaos and pain.

It has been nineteen years since my abortion. Although much has changed in nineteen years, not much has changed for women experiencing an untimely pregnancy. They still face unsupportive partners and employers and are often unaware of the community resources available to them. They undergo abortion not so much out of choice, but out of desperation or as a last resort. I believe women deserve better than this.

Although some women are able to move on from their abortion, many are left with physical or emotional scars that negatively affect their lives for years and sometimes decades.

In all the noise surrounding abortion, women are often forgotten. It is time to stop the noise and start listening to women who have experienced abortion and other pregnancy losses. I am grateful that you have taken the time to listen and I urge you to continue to take steps to understand the impact pregnancy losses have on women.

Mr. BILIRAKIS. Thank you very much.

Doctor Shadigian.

STATEMENT OF ELIZABETH M. SHADIGIAN

Ms. SHADIGIAN. I want to thank this whole Committee on Energy and Commerce and the specific Subcommittee on Health, and especially Congresspersons Barton and Bilirakis for inviting me here. I feel proud to be here on several accounts. I am a mother. I'm a researcher. I'm a medical doctor. I just delivered two babies 2 days ago, and every day of my life I work for women's health.

One of the things I research is violence against women, and another area that is very important to me is women's mental health and pregnancy complications as well. I support ongoing research on how depression affects women, and support furthering our understanding of why some women experience significant depression, some to the point of suicide, especially after pregnancy.

I have worked at the University of Michigan over 10 years now, and I've been a doctor for almost 15 years. Depression is generally viewed—and because I'm a fairly young doctor, over a lifetime, I got to study in Baltimore, so I know a lot of the people around here as well—depression is generally viewed in the medical community like other diseases, like diabetes, like hypertension, like cancer. Theories explaining the cause of postpartum depression typically include changing hormone and brain receptor levels, with research indicating that women at the highest risk for postpartum or depression after pregnancy are those that have been diagnosed prior to pregnancy or even in pregnancy with depression or bipolar disorder.

But, we also know women who have troubled marriages, women who have poor social supports, are also at higher risk.

We also know that about 10 to 15 percent of women experience mild to severe postpartum depression, which is clinically under-diagnosed.

In our own clinic in Michigan, we now are doing pregnancy screens for depression two times in prenatal care and once at the postpartum visit, and so this has been instituted with a liaison with the Psychiatry Department, the OB/GYN Department, and Family Practice, including our Midwife Department, so it's something that can be instituted to try to screen for women during and after pregnancy.

In the past, research has failed to systematically incorporate an analysis of the effects of violence in women's lives as an important contributor to depression. When I was a student at Hopkins, that whole thing about violence against women was never talked about once for all the years I was there. We didn't talk about women being abused as children, women being beaten at home by their partners, or being raped as a teenager. Those things never came up, and it was never even constructed as part of what we should be screening for for depression. So, this is all very new, to think about violence and depression being related in any way at all.

But, we also have not, until recently, realized, and Doctor Stotland actually said this already, that homicide is probably the leading killer of women in pregnancy and the year after pregnancy, homicide, and not far behind is suicide. And that also is some research I've been working on.

Newer research has indicated that the risk of becoming an attempted or completed homicide victim was three times higher for

women abused versus not abused during a pregnancy, and that black women have a threefold increased risk as compared to white women.

And, other studies have shown that homicide is very common among postpartum teenagers, as compared to adult women.

This same research on homicide and suicide after pregnancy reveals that women who terminate their pregnancies, as compared to women delivering a term baby, are twice as likely to die from homicide and two to six times as likely to die from suicide. These associations were not seen with other pregnancy losses, such as still birth or miscarriage.

Violence histories are several fold higher for women who seek termination of their pregnancies as well.

The important thing, this research is not just about abortion, this is research about all kinds of pregnancies and all kinds of death.

Concentration on biology to the exclusion of culture and sexual and physical violence in examining differences in depression creates a misleading picture of risk factors and eventual outcomes. Studying depression, while ignoring physical and sexual violence against women, is like searching for a child hiding in a house without looking in the closets.

In the same manner, research studying only depression after child birth ignores the difficulty millions of women have in this country and what they are faced with following pregnancy losses, depression after miscarriage, still birth and termination of pregnancy.

We must also focus considerable energy on the safety and mental health of women who terminate their pregnancies. They deserve just as much research as women who carry their babies, both deserve it, and remember, we are talking about the same women. Many women choose abortion at some time in their life and then they choose to carry their babies later on.

Improving women's health must include improving mental health and physical and sexual safety. Therefore, improving our understanding of depression after pregnancy is imperative. It's important to save women's lives, to save women like Melanie Blocker Stokes, and the only way we can do that is by getting better research, and we must be looking for that child in the closet.

Thank you.

[The prepared statement of Elizabeth M. Shadigian follows:]

PREPARED STATEMENT OF ELIZABETH M. SHADIGIAN, CLINICAL ASSOCIATE PROFESSOR OF OBSTETRICS AND GYNECOLOGY, UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

Thank you Congressperson Barton and Congressperson Bilirakis for the opportunity to address this Subcommittee.

I am a medical doctor who specializes in obstetrics and gynecology with a special interest in violence against women, women's mental health issues and pregnancy complications. I support ongoing research on how depression affects women and support furthering our understanding of why some women experience significant depression, some to the point of suicide, especially after pregnancy. I am a clinician who sees depressed women everyday in my practice, have co-authored clinical depression guidelines at the University of Michigan and have published research on depression and suicide after pregnancy.

Depression is generally viewed by the medical community like other diseases such as diabetes, hypertension and cancer. Theories explaining the cause of much of postpartum depression typically include changing hormone and brain receptor levels

and thyroid disorders, to name a few, with research indicating that women at highest risk for depression after pregnancy are those who have been diagnosed with prior major depression and/or bipolar disorder, marital difficulties and a general lack of social support. About 10 to 15 percent of women experience mild to severe postpartum depression, which is clinically under-diagnosed.

In the past, research has failed to systematically incorporate an analysis of the effect of violence in women's lives as an important contributor to depression. Equally important, but routinely overlooked and ignored, is the data that homicide is a leading cause of pregnancy-associated death (*the death of a woman from any cause while pregnant and during the year after pregnancy*) and that suicide is also a significant cause of death.

Newer research has indicated that the risk of becoming an attempted or completed homicide victim was three times higher for abused women versus non-abused women during pregnancy and that black women have a three-fold increased risk as compared to white women. Other studies report higher rates of homicide among postpartum teenagers as compared to adult women.

This same research on homicide and suicide after pregnancy reveals that women who terminate their pregnancies, as compared to women delivering a term baby, are twice as likely to die from homicide and almost two to six times as likely to commit suicide. These associations were not seen in other forms of pregnancy loss. Violence histories are several-fold higher in these same women who seek termination of their pregnancies.

In addition, self-harm and psychiatric hospital admission because of suicide attempt is more common in women who terminate their pregnancies, while rates of suicide and suicide attempt are half or less for women with full term pregnancies compared to the general population.

The concentration on biology to the exclusion of culture and sexual and physical violence in examining differences in depression creates a misleading picture of risk factors and eventual outcomes. Studying depression while ignoring sexual and physical violence against women is like searching for a child hiding in a house without looking in the closets. In the same manner, research studying only depression after childbirth ignores the difficulties that millions of women in this country are faced with following pregnancy losses—depression after miscarriage, stillbirth and termination of pregnancy.

We must also focus considerable energy on the safety and mental health of women who terminate their pregnancies. Not doing so is to ignore an important area of women's mental health research. A number of studies note the association between the termination of pregnancy and either suicide or suicide attempt. This is an objective outcome which is seen only after termination of pregnancy rather than before and indicates either common risk factors for both choosing termination of pregnancy and attempting suicide such as depression or the harmful effects of termination of pregnancy on mental health.

Improving women's health must include improving mental health and physical and sexual safety. Therefore, improving our understanding of depression after pregnancy is imperative. We must look for the child in the closet.

Mr. BILIRAKIS. Well, there's so much here. I am gathering, when were you last in medical school?

Thank you so very much, Doctor.

Ms. SHADIGIAN. I finished, I completed medical school in 1990.

Mr. BILIRAKIS. 1990, and at that time, apparently, they were not focusing at all on this type of a problem, so far as teaching is concerned, is that right?

Ms. SHADIGIAN. Correct, and, in fact, the Chair of Psychiatry, I took extra courses from him, because I wanted to know more about things, and we never discussed those kinds of things. It just wasn't even the things we looked at at that time.

Mr. BILIRAKIS. Do you know, has that changed now? Have they improved in this regard, do you know?

Ms. SHADIGIAN. I think in general people are becoming more aware, but I think it's something that takes a long time to seep into the consciousness to actually change an outlook of a whole field like psychiatry.

Of course, you know, now post-traumatic stress disorder is in the DSM-IV, so things are starting to change, but I think just looking at the long view of things, in general it's not mandatory in psychiatric research around depression, around suicide, around homicide, to actually screen for violence, and that has to be mandatory for us to understand the situation women are in in their homes.

Mr. BILIRAKIS. Thank you, Doctor.

Do you—it would be interesting to try to figure out what we could do about that, I suppose, making the medical profession more aware of the problem.

How about NIH, if you know, are they adequately researching postpartum depression?

Ms. SHADIGIAN. I know that it's an important issue for many researchers, and we know it's important for women and families.

I think some of the things that they need to focus on is making sure, no matter what the study is, is that we take an adequate violence history from all women in these studies, that that should be a mandatory part of each and every study, to understand the violence history and understand what their obstetrical history is, which means that we know how many miscarriages, how many abortions, in what trimester, how many times their babies were born early but fine, and at term and fine. I mean, we need to understand all those things before we can put these pieces together, and we need to look forward, not just backwards, we need to do studies that start with 15, 16 year olds, and follow them throughout their lifetime so we can see which of those girls and then young women have problems like Melanie Stokes did.

Mr. BILIRAKIS. So, are you saying then that you feel that we would be short changing our research efforts on depression if we ignore research of all sorts of depression as related to pregnancy, which would include abortion?

Ms. SHADIGIAN. I think what we have to do is stop worrying about the politics part of it and start thinking about women in general, that we need to focus research to help women, and women are going to make those choices or not, depending on their individual situation.

So, I want to be pro information. I want to be pro science, and I think women deserve that in America.

Mr. BILIRAKIS. All right.

Well, but again, you are not familiar then with the extent, if at all, that NIH is spending on research on this particular subject.

Ms. SHADIGIAN. No one has briefed me on the exact number of dollars spent in which kind of research.

Mr. BILIRAKIS. Do you know if that research is taking place at all?

Ms. SHADIGIAN. Oh, yes, yes, there are, and, in fact, I have many colleagues at the Depression Center at the University of Michigan who, in fact, have NIH grants, and they are trying to not just look at postpartum depression, but look at what the effects are on small children whose mothers are depressed.

So, I know there's research ongoing, I'm just not the financial expert.

Mr. BILIRAKIS. Well, Ms. Fredenburg, do you know, I don't know whether you've thought about taking the opportunity to check in

terms of what research has taken place or what educational aspects might be taking place soon. Do you know, can you add anything as far as your knowledge is concerned, because as a result of your experience you've become very much involved in this issue.

Ms. FREDENBURG. I have, and while I'm certainly not an expert in that area, I think the hearing today has already highlighted that there certainly is a lack of knowledge, because of a lack of statistical data and a lack of studies on the effect of pregnancy losses and, in particular, abortion losses upon women.

And, since we have millions of women who do undergo abortions each year, we need to know that information, and after 30-some years of legalized abortion, to me as a woman's health advocate it's shocking and disturbing that we don't have that type of information where we can be assisting women.

Mr. BILIRAKIS. Thank you.

I certainly understand you to say, and would agree, that rather than try to downplay the effect that abortion would have on depression, that we should be looking at depression in all women as a result of pregnancy, regardless of whether it might be abortion or whatever the case might be.

Thank you.

Mr. Rush has left. That being the case, Ms. Capps is recognized.

Ms. CAPPS. Thank you, Mr. Chairman.

I was a bit surprised to learn that this panel who was part of the hearing today. To the best of my knowledge, so-called post-abortion syndrome has never been shown to exist by any legitimate scientific or medical study, and we've heard in the last panel about the study that C. Everett Koop, the Surgeon General, was asked to conduct, and his acknowledgment that even though he was anti-choice he could find no direct correlation between an abortion and a situation of having physical or psychological harm to a woman.

I do see a connection between this panel and the one previous, in that, Ms. Fredenburg, your eloquent testimony to your personal experience, and, Doctor Shadigian and the two who preceded you in the panel, certainly give testimony to the fact that mental health services for women are very important, and that we do not have parity in our country, and that there are efforts that we really should champion in the House as are being pushed to the degree that they are in the Senate, to make sure that there is opportunity for women, no matter what their story, to have access to mental health.

I do want to question, I want to get at a couple of things. Just one specific thing, because I'm concerned about statements made without verification. Doctor Shadigian, in your testimony on March 3 before the Senate you said this, and this is a quote, "Induced abortion is associated with increased risk in maternal suicide," and today you also referenced that topic, saying that women who terminate their pregnancies compared to women who deliver a baby to term are twice as likely to die from homicide and almost 2 to 6 times as likely to commit suicide, and I want to ask you what research you have to back up that statement?

Ms. SHADIGIAN. That's a great question, I'm glad you asked that, and I appreciate getting the opportunity to discuss that.

What I got to help was something called a systematic review of the literature, and what we do when we want to learn more about a specific topic is actually go to the library, or the libraries, and do searches of all the different——

Ms. CAPPS. Excuse me, I don't want to cut you off, but I have some other questions, too, and I just want to know, would you cite the source for that particular study, please?

Ms. SHADIGIAN. Yes, it's cited in my review article, "Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence." It's in table number——

Ms. CAPPS. What source is given at the bottom of that table then, if you would, so that I can have it on record?

Ms. SHADIGIAN. Absolutely, I will give you the three different studies, so you can know that. There are ten studies that look at it in Table 7, and the specific ones that I'm talking about are cited in this table. There's actually ten of them, and three of them show an increased risk in suicide——

Ms. CAPPS. Is there an author? Is there an author to the study that you could just list for the record so we could verify it?

Ms. SHADIGIAN. Yes, I'd be glad to. It's Reardon.

Ms. CAPPS. Okay.

Ms. SHADIGIAN. And, it's "Fetal Deaths Associated With Pregnancy Outcome: A Linkage-Based Study in Low-Income Women."

Ms. CAPPS. Okay, so I'd like to have that entered into the record if I could.

Mr. BILIRAKIS. Would you like to put your entire article into the record?

Ms. SHADIGIAN. I think that would be helpful, because it actually goes over each and every study. The important thing is also, this has all been since Koops'——

Mr. BILIRAKIS. Yeah, I don't mean to take up Ms. Capps' time, I just thought maybe you might just prefer to have the entire article put into the record.

Ms. CAPPS. That's fine, I would like to be able to get back at this article.

Mr. BILIRAKIS. Without objection, that will be the case.

Please continue.

Ms. CAPPS. I'm concerned—I want to get to something further. I have been aware of a climate in this administration, and also in the House, that has a politicizing actually of women's reproductive health from my perspective, based on an anti-choice format, and coming from that vantage point.

One example of it is the Food and Drug Administration ignoring recommendations from its top scientists and not allowing an emergency contraceptive to be sold over the counter, which actually would have the net result of reducing the number of abortions. And so, this is part of the context, I believe, in which even this hearing today is coming from, not that particular issue, but I cite it as an example.

And I'm very concerned also that you are trying to get at documentation coming from personal lives that would be shared, that would become then a part of a story, and how we can mesh that with the desire and the ultimate requirement that we allow women to have privacy over their personal lives, and that eliciting infor-

mation for studies such as these that you are citing, and also are being proposed, would be one way to get to document that personal and private information that then could be used in harassing and held against people.

If you could comment on that, please, Doctor Shadigian.

Ms. SHADIGIAN. I'd be glad to.

The question is, are these women who are going to be in part of studies obtaining informed consent?

Ms. CAPPS. Yes.

Ms. SHADIGIAN. So, whenever we have studies and review boards, they have to look and make sure women are being properly told what the risks and benefits of participating in studies are.

And, in fact, that's why they have institutional review boards and they are all ones that have to talk to Federal agencies to get funding.

So, in all these studies that maybe be proposed in the future, these are all people who can voluntarily give their information, no one is being coerced to give it. I think women in America want to know, is there an increased risk of anything.

Ms. CAPPS. Just could I add that there's also the opposite side that one can state, if you look outside an abortion clinic and you see people standing there with signs of protest, there is a climate today, I would posit, that would really send a chill down for many women before they would want to come forth, though they are desperate and needing help, and though we want to get information, because there is this underlying bias that would want to use it for a particular——

Mr. BILIRAKIS. Time is long expired.

Did you want to respond very quickly to Ms. Capps' comment?

Ms. SHADIGIAN. I just think we need to change the climate. We need to say that this is about women's health and not about anything but that, and I think what we have——

Mr. BILIRAKIS. Not about abortion, not about anything else, it's women's health as a result of depression, resulting from pregnancy, is that right?

Ms. SHADIGIAN. I think we just need to get above the fray of, this isn't about is abortion legal or not, it is legal in America, so let's forget that for a moment and start talking about women's health, mental health and physical health, and how can we improve it. I think we need to just get the discussion somewhere other than at the legal part.

Mr. BILIRAKIS. Thank you, Doctor. That's what some of us are trying to do.

Mr. Pitts to inquire.

Mr. PITTS. Thank you, Mr. Chairman.

We've heard a lot about Doctor Koop and the statement in the testimony was, "The psychological effects of abortion are minuscule from a public health perspective." The staff has given me his letter to President Reagan, dated January 9, 1989, when he was asked to prepare a comprehensive report on health effects of abortion on women. I don't find that sentence in the letter at all, in fact, it concludes, "I regret, Mr. President, that in spite of a diligent review on the part of many in the public health service, and in the private sector, the scientific studies did not provide conclusive data about

the health effects of abortion in women. I recommend that consideration be given to going forward with appropriate prospective studies."

So, Mr. Chairman, just for the record, I would like to submit that letter for the record.

Mr. BILIRAKIS. Without objection, that will be the case.

[The information referred to follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

The Surgeon General of the
Public Health Service
Washington DC 20201

January 9, 1989

Mr. Ronald Reagan
The President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

On July 30, 1987, in remarks at a briefing for Right to Life leaders, you directed the Surgeon General to prepare a comprehensive report on the health effects of abortion on women. It was clear from those remarks that such a report was to cover the mental, as well as the physical, effects of abortion. A review of the scientific literature, the expertise of the Public Health Service, and the experience of national organizations with an interest in this issue form the basis for my conclusions.

The health effects of abortion on women are not easily separated from the hotly debated social issues that surround the practice of abortion. Therefore, every effort has been made to eliminate the bias which so easily intrudes even into the accumulation of scientific data. In this study I have purposely avoided any personal value judgement vis-a-vis abortion as a social issue.

I have approached this task as I did in writing the AIDS report which you requested in 1986. Scientific, medical, psychological, and public health experts were consulted. I met privately with 27 different groups which had philosophical, social, medical, or other professional interests in the abortion issue. The process involved groups such as the Right to Life National Committee, Planned Parenthood Federation of America, the U.S. Conference of Catholic Bishops, the American College of Obstetricians and Gynecologists, and women who had had abortions.

In summary of the situation, each year approximately 6 million women become pregnant; of that number 54 percent or 3.3 million of those pregnancies are unplanned. Over 1.5 million women, or 25 percent of those pregnant, elect abortion each year. Since the legalization of abortion in 1973, over 20 million abortions have been performed. Even among groups committed to confirming a woman's right to legal abortion there was consensus that any abortion represented a failure in some part of society's support system, - individual, family, church, public health, economic, or social.

At the time the report was requested, there were those advising you and intimately involved with the social issues of abortion who truly believed that such a report could be put together readily. In the minds of some of them, it was a foregone conclusion that the negative health effects of abortion on women were so overwhelming that the evidence would force the reversal of Roe v. Wade.

There were also others who truly believed differently. While they acknowledge that any surgical procedure done 1.5 million times a year may have some negative health effects on women, in their minds the positive effects of abortion - release from the unwanted pregnancy - far outweighed the perceived negative results.

It is difficult to label the opposing groups in the abortion controversy. Those against abortion call themselves pro-life. On the other hand, those who are not pro-life say they are not pro-abortion; rather, they refer to themselves as pro-choice and supporters of a woman's right to choose abortion.

It is also true that some who are pro-choice are personally opposed to abortion. It is not clear to them where the lines should be drawn between the right of the fetus and the right of the mother. So the pro-choice forces are not monolithic.

Nor are the pro-life forces monolithic. Many ardent pro-life individuals who are dedicated to perserving the life of the fetus do not consider contraception to be ethically, morally, or religiously wrong. But others in the pro-life camp do; indeed, some equate contraception with abortion.

I believe that the issue of abortion is so emotionally charged that it is possible that many who might read this letter would not understand it because I have not arrived at conclusions they can accept. But I have concluded in my review of this issue that, at this time, the available scientific evidence about the psychological sequelae of abortion simply cannot support either the preconceived beliefs of those pro-life or of those pro-choice.

Today considerable attention is being paid to possible mental health effects of abortion. For example, there are almost 250 studies reported in the scientific literature which deal with the psychological aspects of abortion. All of these studies were reviewed and the more significant studies were evaluated by staff in several of the Agencies of the Public Health Service against appropriate criteria and were found to be flawed methodologically. In their view and mine, the data do not support the premise that abortion does or does not cause or contribute to psychological problems. Anecdotal reports abound on both sides. However, individual cases cannot be used to reach scientifically sound conclusions. It is to be noted that when pregnancy, whether wanted or unwanted, comes to full term and delivery, there is a well documented, low incidence of adverse mental health effects.

For the physical situation, data have been gathered on some women after abortions. It has been documented that after abortion there can be infertility, a damaged cervix, miscarriage, premature birth, low birth weight babies, etc. But, I further conclude that these events are difficult to quantify and difficult to prove as abortion sequelae for two reasons. First, these events are difficult to quantify because approximately half of abortions are done in free-standing abortion clinics where records which might have been helpful in this regard, have not been kept. Second, when compared with the number of abortions performed annually, 50 percent of women who have had an abortion apparently deny having had one when questioned. Further, these events are difficult to <u>prove</u>, as sequelae of abortion because all of these same problems can and do follow pregnancy carried to term or not carried to term, - indeed can occur in women who have never been pregnant previously. Clearly, however, the incidence of physical injury is greater in instances where abortions are performed or attempted by those not qualified to do them or under less than sterile conditions.

I have consulted with the National Center for Health Statistics and Centers for Disease Control about the design of appropriate studies which could answer the questions dealing with the physical and psychological effects of abortion.

There has never been a prospective study on a cohort of women of child-bearing age in reference to the variable outcomes of mating. Such a study should include the psychological effects of failure to conceive, as well as the physical and mental sequelae of pregnancy, - planned and unplanned, wanted and unwanted - whether carried to delivery, miscarried, or terminated by abortion. To do such a study that would be above criticism would consume a great deal of time. The most desirable prospective study could be conducted for approximately $100 million over the next five years. A less expensive yet satisfactory study could be conducted for approximately $10 million over the same period of time. This $10 million study could start yielding data after the first year.

There is a major design problem which must be solved before undertaking any study. It is imperative that any survey instrument be designed to eliminate the discrepancy between the number of abortions on record and the number of women who admit having an abortion on survey. It is critical that this problem of "denial" be dealt with before proceeding with furtner investigations.

This is where things stand at this moment. I regret, Mr. President, that in spite of a diligent review on the part of many in the Public Health Service and in the private sector, the scientific studies do not provide conclusive data about the health effects of abortion on women. I recommend that consideration be given to going forward with an appropriate prospective study.

Sincerely,

S/

C. Everett Koop, M.D., Sc.D.
Surgeon General, U.S.P.H.S.

Mr. PITTS. I don't know how much time—I'd like to go on quickly, Doctor Shadigian, you've heard the questions of the previous panel characterizing your testimony before you even had a chance to testify. Would you like to respond in any way to set the record straight?

Ms. SHADIGIAN. Well, I think that what I try to do is to look at hard outcomes. What I try to do is to promote good science, and I think that that's where this whole issue of appropriations needs to go to, is we need to do well-designed studies, and we need to be able to make good conclusions. And I believe Doctor Koop was actually asking for that in 1989, that there just weren't very good studies at that point so he couldn't draw any conclusions.

Mr. PITTS. Now, have you ever witnessed, or yourself experienced, the hostility within the medical community toward those who research the possible negative effects of abortion on women?

Ms. SHADIGIAN. Well, I think what's hard in the medical community, it's hard to even talk about it because everyone is afraid of looking one way or the other. Everyone wants to pigeonhole somebody else as to being biased about one thing or another, and everyone doesn't want to actually talk about the science as much.

And, I think, again, if we can just elevate our discussion to the scientific level, rather than stay at the personal or political level, then I think that that's where we all want to go to, and I think it's the higher ground that everyone can agree with, is that we all are concerned about women's health and women's mental health, and want to prevent suicides like Ms. Blocker-Stokes. I mean, we all are on the same page on that, and I think whether a woman is hurting herself after a termination of pregnancy or after a full-term birth, we all want to help that woman, and I don't think that that's something that's hard to see.

Mr. PITTS. In your opinion, are we shortchanging our research efforts on depression if we ignore research with respect to abortion, you know, what steps should scientists take to better understand this whole issue of either postpartum or post-abortion depression?

Ms. SHADIGIAN. Well, I think what we need to do is actually to put all the pieces in order. We need to be able to put women's violence histories in our research. We need to put women's obstetrical histories in our research, and we need to know who does have a prior history of depression and mania, and all the other kinds of psychiatric diagnoses, which women have those histories.

You know, most women won't even talk about their prior history because they are scared. So, I think we have to pull away the stigma of mental health issues before we can do the research, and we are doing that on a day-to-day basis.

But, until we can do that, it's going to be hard to do the research, and we have to all sort of get on the same page, and I think we can do it. I'm not depressed about that at all, I think we are very positive here.

Mr. PITTS. Ms. Fredenburg, you testified about the ways in which you reacted negatively to abortion. Are there other ways in which women react? And you talked about your 9 year old son, how the prospect of telling him about your abortion breaks your heart. It seems like the easiest thing to do would be not to tell him, and avoid the pain, you know, why tell him? Would you like to respond?

Ms. FREDENBURG. Yes, because of my own experience, but beyond that, because of just the vast number of women and other family members involved in abortion experiences, I made the decision to be public about my abortion experience, so that women who may be experiencing similar things would know that they are not alone, they would know that there is help, and because I think that in this highly politicized environment on this issue that we need to actually see real people and what they go through.

And so, that's a decision that I have made, but I do realize that that then has consequences for my family and, in particular, my children, because he will eventually find out, and he will then have to cope and to deal with this, but I do believe that it is for the greater good.

Mr. PITTS. Thank you, Mr. Chairman.

Thank you very much.

Mr. BILIRAKIS. Mr. Rush to inquire.

Mr. RUSH. Yes. Thank you, Mr. Chairman.

I have I believe one question, I'm not sure, it might lead to some additional questions.

First of all, Ms. Fredenburg, I want to say to you that we thank you so much for sharing your experiences, and we certainly—I've tried to listen to your experiences with the empathy that I could muster, and I want you to know that I appreciate you appearing as a panelist before this subcommittee. Thank you so very much.

I want to ask Doctor Shadigian, from the data that you've been able to observe, is there any similarities, and what are the similarities, if any, between what you call postpartum-post-abortion depression and postpartum depression?

Ms. SHADIGIAN. Well, it's funny, that's a great question. You know, depression is depression. You know, depression has certain

signs and symptoms. Depression affects mood and how people think about themselves, and so we've added those other terms onto the word depression, okay? So, whether depression is after childbirth, or after abortion, or after a car accident, or after something else, we put these sort of adjectives ahead of the word depression. And so, that's the real question, are there triggers for major depression and what are they, because, you know, people who are pregnant do have hormone levels, you know, and then they do drop, and we know that, but we are not sure if they are completely related or not.

So, there are similarities, but the problem is, people are afraid to do that other research, and that's why I'm saying we can't just look at one thing, we've got to look at the whole thing around pregnancy, and if there is losses, if there is, you know, normal birth, you know, we do know that a subset of women feel awful afterwards, and it's not something that they can "will themselves out of," that it is a metabolic and receptor level kind of thing, but we don't know what the predisposing factors are.

So, we have to be really clear that, you know, we need to study depression, in general and depression in women, and depression in and around pregnancy, to answer those questions well.

Mr. RUSH. There is, I'm trying to locate here, is there any data or any census that you might have heard about or might have in your possession, of violent incidences that have been attributed to what you call postpartum, I mean, post-abortion depression, that you can identify?

Ms. SHADIGIAN. Are you asking about suicide or homicide?

Mr. RUSH. Both.

Ms. SHADIGIAN. Okay. The studies that are in my review of the ten studies did show that women who'd had abortions in the year after their abortion had a higher rate of suicide, and that is controlling for prior psychiatric history, unlike what Doctor Stotland said, they actually—that was why these are so powerful, these studies, because they actually controlled for prior psychiatric history and prior depression.

And so, I'm not saying I understand why that subset of women killed themselves, I don't know why, but we need to look at it, and that's why I'm trying to take this out of the realm of just looking at a procedure like abortion and get it out into the realm of women's health and what women's risk factors are.

So I think there are data out there, and they are pretty decent data, but it's not completely explanatory why, and that's why I think, you know, focusing the direction of money in that direction to see what the differences are and what the risk factors are will help women not feel so bad that they feel like they want to hurt themselves for whatever reason, for psychotic reasons, or for reasons of feeling they have shamed their family, or for whatever reason they are feeling that way.

Mr. RUSH. I yield back, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Doctor, you co-authored the Clinical Depression Guidelines for use at the University of Michigan.

Ms. SHADIGIAN. That's correct, two times.

Mr. BILIRAKIS. Two times.

Have you submitted those to any of the medical journals, you know, as usually researchers would do and what not? I mean, have you made that available so that it might be, you know, a resource for physicians around the country?

Ms. SHADIGIAN. It's actually available on our University of Michigan home page, so it's available for people to look at and log in on, and it actually has tables of all the common drugs used for depression, how much they cost, how do you diagnose depression in different groups of people, and what special circumstances are. So, they are not just about women, they're like all depression, it's a big 30-page document. So, it's an actual very big resource. I'd be glad to give a copy of that for the committee, if that would be helpful.

Mr. BILIRAKIS. I think that would be great to have that, but you know what, I'm so much concerned about education, what we find in our hearings here, we will disagree on technicalities and political, and we all have biases because we are human beings and God has placed biases into us, but at the same time I think we all agree that more often than not more education for the general public and for medical doctors, nurses, et cetera, is so very important.

Anything that will be helpful in that regard.

Is there, and I don't know, maybe Ms. Capps knows, is there an expert anywhere in the country who is kind of the authority on depression in women, particularly, as it involves pregnancy, or after pregnancy, but still depression in women?

Ms. CAPPS. Doctor Stotland.

Mr. BILIRAKIS. Well, all right, I know she testified, is she the—do you agree, Doctor Shadigian, that she should be considered the authority? She's still in the room.

Ms. SHADIGIAN. Well, I don't think there's one authority on this whole issue. I think that, you know, we all come from our own biases and perspectives.

I think that OB/GYN physicians see pregnant women constantly, and are the ones who follow them in pregnancy and afterwards, but are not exclusive. Family practice physicians do deliveries, and so do midwives.

But, in terms of depression, it's a very good question. The whole thrust has been to actually educate primary care physicians to identify depression and to identify people at higher risk, and only refer, in fact, the most serious cases, people who actually have psychosis and all those more serious symptoms to psychiatrists.

And, in fact, most depression is treated by primary care physicians, internal medicine, OB/GYN, family practice, et cetera, and even pediatricians for their kids with depression.

Mr. BILIRAKIS. And yet, you tell us that medical schools are not emphasizing that adequately.

Ms. SHADIGIAN. No, I said violence against women, that's before, but they are trying to do that more and more, and I think the emphasis is to see that it's the generalist physician, who is treating the bulk of depression in America.

Mr. BILIRAKIS. Well, all right, thank you.

I thank you both. Ms. Fredenburg, you came a long way, and it took a lot of courage for you to be willing to do it, and we really are very grateful to you. And, Doctor, you are quite a witness, and

we are all grateful that you're still an OB/GYN. There aren't too many of you around anymore unfortunately, as a result of——

Ms. CAPPS. Mr. Chairman, is there time for another round of questions?

Mr. BILIRAKIS. No, I'd rather-well, I'd rather not go through another round, but they have to make a flight, as I understand it, that's what I was told earlier, but I mean if you have something for a minute or so, go ahead.

Ms. CAPPS. I'd love to follow up on some of the things you brought up, if the panel is willing and can stay for a couple minutes.

Would you mind if I ask a couple questions?

Mr. BILIRAKIS. Well, you can take a couple minutes.

Ms. CAPPS. Okay.

Mr. BILIRAKIS. Don't ask a couple questions, because that could take 10 minutes.

Ms. CAPPS. I wanted to, because, Mr. Chairman, you turned to me and said is there one authority, and I think everyone cringes at the thought of being—having one authority on women's mental health issues. But, we do have one Federal agency, which is the National Institutes of Mental Health, and I just wanted to make sure that when Doctor Shadigian says that the studies that she's citing do take into account prior conditions before studying the ten studies that you referenced in your literature, that study post-abortion depression or symptoms, that there is a body of evidence to the contrary that those studies do not adequately explain and bring to light pre-pregnancy conditions that would certainly have a bearing on the outcome of any procedure, whether coming to term or termination of a pregnancy. So, I think that needs to be part of the documentation today.

And, if there is time I wanted to ask you a question, Doctor Shadigian, because you have mentioned a couple of times, and I think today as well, that abortion is associated with breast cancer, that in your testimony before the Senate, and I want to get your answer on the fact that I'm under the impression that this has been contraindicated by a major group of health experts.

Have you made the assertion that abortion is associated with breast cancer?

Mr. BILIRAKIS. Well, you know, I gave you an extra couple of minutes, and now you are changing the subject.

Ms. CAPPS. Well, we are talking about——

Mr. BILIRAKIS. The subject of the hearing is depression after pregnancy.

Ms. CAPPS. [continuing] physical and-breast cancer is a pretty big topic.

Mr. BILIRAKIS. Do you have a very brief quick answer to that?

Ms. SHADIGIAN. Well, I think the problem that—a quick answer is that we are not going to see the big picture. I think the problem around even answering that question is it's going to be, you know, a short, one-sentence answer to a very complex issue.

And, I think the bottom line of that issue is, we need to do a good study, a prospective study of women, you can include women's health issues like depression, breast cancer, just whole—you can go down a list of things that are important, and do a prospective study

and then, instead of just quoting other studies that are retrospective or look backwards, and maybe aren't as well designed, we'll be able to answer that question more definitively——

Ms. CAPPS. But we don't have an association at the moment. There's a lot of literature out there in clinics and other places that if you have an abortion your chances of getting breast cancer are very high. Do you agree with that?

Mr. BILIRAKIS. Well, now——

Ms. CAPPS. That could be a yes or no answer.

Mr. BILIRAKIS. [continuing] you know, that's why we can't get anything done around here. You know, we are concerned about depression in women after pregnancy. It's a wide enough subject as it is, and yes we are concerned about cancer, whether there's any effect of abortion on cancer and that sort of thing, but that's not the subject matter of our hearing. And, instead of concentrating on what the doctor said so many times, which the concern is depression in women after pregnancy, we keep going back to our bias insofar as abortion is concerned, and I'm not sure what good that is doing as far as the hearing goes.

Well, all right, if there's nothing more, I think I am deeply——

Ms. CAPPS. If I could have an answer, because it came up in the testimony. I mean, I just would like to—I didn't hear it clearly enough, but the association was made in your testimony.

Ms. SHADIGIAN. I think there's a large body of literature that shows both sides, and that the studies are incomplete, and that we will be able to answer that question more definitively when a good prospective study, or several ones around the world, are conducted.

And so, therefore, it is important that, you know, this Congress actually think prospectively and try to help the researchers design these studies by funding them.

Ms. CAPPS. In the meantime it's used as a scare tactic. I appreciate your answer, though.

Mr. BILIRAKIS. The hearing is thus concluded. We, as we always do, furnish you written questions, and we would hope that you will respond to those questions in writing, you know, as timely as you might.

And again, our gratitude for your being here. It's turned out to be a pretty good hearing. I just wish we could have kept it more on subject, but that's the way it goes.

Thank you so very much, both of you.

The hearing is adjourned.

Ms. SHADIGIAN. Thank you, sir.

[Whereupon, at 3:46 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT ON BEHALF OF THE AMERICAN CANCER SOCIETY

The American Cancer Society would like to thank Congress and particularly Chairman Biliraiks and the House Energy & Commerce Committee for their strong support of an initial physical for Medicare beneficiaries, which resulted in Section 611 of the Medicare Modernization Act (MMA), otherwise known as the "Welcome to Medicare" visit. The Society—along with our partners in the Preventive Health Partnership (PHP), the American Diabetes Association and the American Heart Association—has been a strong advocate for the initial physical because we believe this new benefit will help promote prevention and early detection and will result in lives saved and improved quality of life for our nation's seniors.

Now that Section 611 has been enacted as part of the MMA, we have been working with the Centers for Medicare & Medicaid Services (CMS) on the implementation and with the PHP on outreach initiatives. While we would have liked to testify, the Society appreciates this opportunity to communicate our interest in and perspective on this critical new benefit to the House Energy & Commerce Committee's Subcommittee on Health.

The Society Supports a Comprehensive Physical

Recognizing the strong value of early detection, Congress has already provided Medicare coverage for breast, cervical, colon, and prostate cancer screenings. While screening rates have increased since the coverage became effective, they are still below their optimum levels. Studies have shown that a physician's recommendation is key to increasing screening rates; however, before Section 611 was enacted, Medicare did not cover a routine physical or other type of "wellness visit" where a conversation between a doctor and patient about cancer screening can easily take place. The American Cancer Society advocated for an initial "Welcome to Medicare" visit for new Medicare beneficiaries so that patients and their health care providers could have time dedicated to discussing the patient's health risk as well as recommended disease prevention strategies, such as smoking cessation, better nutrition and increased physical activity, and needed cancer screenings that could either be performed as part of the physical or, if needed, scheduled through a referral. We recognize the challenges Congress faced in creating the benefit and the challenges CMS is now facing with respect to implementation. Overall, the Society is pleased with the completeness of the new physical as outlined in CMS' recent proposed regulation, in particular that it will include a review of a patient's comprehensive medical and social history, which will include reviewing their family history, tobacco use, diet, and exercise. We also appreciate the inclusion of several health measurements, including the patient's height, weight, blood pressure, visual acuity and other factors deemed appropriate by the health care provider based on the patient's examination. While we recognize that patients fill out paper work that captures some of this information prior to their enrollment in Medicare or when they visit a new provider, we feel it is important to use the opportunity presented by the physical for the physician and patient to have a specific discussion about the patient's medical and social history. Many physician practices ask patients to fill out a survey before their first visit. Our hope is that physicians will be able to use the information collected on these types of forms as a discussion tool during the visit.

The need for such a visit is underscored in medical literature. For instance, in a study of 2,775 primary care patients, the strongest factor in whether or not an individual had undergone screening, was whether or not they had a specific visit for a health check-up in the previous year.[1] In other words, relying on a doctor to mention screening during their sporadic contact with patients is not practical—and does not work. Furthermore, an analysis in the *Annals of Internal Medicine* found that planned visits dedicated to prevention are one of *the most effective ways* to get people screened.[2] Dedicated check-ups provide the opportunity to plug cracks in the system and assure that patients get their necessary preventive care.

It is our understanding from conversations with Committee staff and CMS that cancer screenings that can be performed by the health care provider during the physical (such as pap smears and prostate-specific antigens) may in fact be performed during the visit instead of requiring a referral. We applaud this approach, as it ensures that patients and physicians can make the most of this visit. However, we feel that there is some ambiguity in the proposed regulatory language regarding this point and have therefore sought clarification from CMS on this specific issue.

Ways in Which the Physical can be Improved

Allow CMS to Add New Preventive Services

As a leading source of cancer screening guidelines, the Society is well-aware that science advances quickly and therefore frequently reviews and updates our guidelines. Currently, Medicare covers the following cancer screening tests, which are inline with the Society's recommendations:

- Breast Cancer Screening: annual mammograms and regular clinical breast exam
- Prostate Cancer Screening: annual digital rectal exam and annual prostate-specific antigen test (PSA)

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[1] Sox CH, Dietrick AJ, Tostenson TD, Winchell CW, Labaree CE. Periodic health examinations and the provision of cancer prevention services, Arch Fam Med. 1997:6:223-30.

[2] Stone EG, Morton SC, et al. Interventions that Increase Use of Adult Immunization and Cancer Screening Services: A Meta-Analysis. Annals of Internal Medicine. 2002;136:641-651.

- Cervical Cancer Screening: pelvic exam every two years and pap smear (either a conventional pap test, or a liquid based-pap cytology tests such as Thin Prep) every two years
- Colorectal Cancer Screening: beneficiaries have the choice of one of five options annual Fecal Occult Blood Test (FOBT)
- Flexible Sigmoidoscopy every four years
- Flexible Sigmoidoscopy every four years + annual FOBT
- Colonoscopy every ten years for average risk individuals and every two years for those at high risk
- Double Contrast Barium Enema as an alternative to flexible sigmoidoscopy or colonoscopy

The Society was very pleased that Congress included a provision in Benefits Improvement and Protection Act of 2000 (BIPA) that not only expanded colonoscopy coverage to include average risk individuals, but also included language that gave the Secretary the authority to update Medicare coverage for colorectal cancer screening "*in consultation with appropriate organizations.*" Congress recently also gave CMS this specific authority through the MMA to update cholesterol screening. This type of language wisely gives the Secretary the authority to ensure that Medicare screening benefits are in line with the current state of the science and guideline recommendations.

Recently, a new FOBT test—an immunochemical test, or an iFOBT,—was added to the Society's colorectal cancer screening guidelines, since it was found to be more patient friendly, and likely to be equal or better than guaiac-based tests in sensitivity and specificity. We were very pleased that the BIPA language allowed CMS to update the colorectal cancer screening coverage in a timely and similar fashion to include iFOBT. Given the success that we have had with this language in relation to improving the colorectal cancer screening benefit, we feel that it is important that CMS be given the authority to update other Medicare coverage for preventive services in a similar fashion and would be pleased to work with Congress to this end.

In giving CMS the authority to add preventive services, we would ask that the language regarding with whom CMS consults be kept consistent with the existing colorectal cancer and cholesterol screening language. Congress has previously considered directing CMS to rely solely on the recommendations of the United States Preventive Services Task Force (USPSTF). While USPSTF serves an important function and is widely respected in their guidelines recommendation process, their limited resources have in the past prevented them from being as responsive to current evidence as such organizations as the American Cancer Society.

The USPSTF is known for conducting comprehensive assessments of clinical prevention services; however, the timeliness of these assessments has been cited as a concern by the Institute of Medicine (IOM) in its 2003 report, "Fulfilling the Potential of Cancer Prevention and Early Detection." While the USPSTF updated its prostate, breast, and colorectal cancer screening guidelines in 2002 and its cervical cancer screening guidelines in 2003, the IOM noted that the previous USPSTF guidelines for these vital tests were last issued in 1996—a time lag spanning six to seven years. The IOM report concluded that "assessments of prevention services are needed on a continual basis to ensure that public health recommendations are current and incorporate the latest scientific evidence."[3] The report also acknowledged that a significant barrier to USPSTF issuing more timely guidelines is that it has limited resources and that this would have to be rectified before the Task Force could improve its responsiveness

Further, the Society notes that there are screening tests we currently recommend and are covered by Medicare that are not yet recommended by the USPSTF (e.g., liquid based-pap cytology tests such as Thin Prep). The American Cancer Society feels strongly that existing coverage for cancer screening tests should remain intact. Rolling back coverage for tests such as Thin Prep would be a step backwards in bringing the Medicare program up to date with proven disease prevention and early detection strategies.

Remove Cost-Sharing for Preventive Services

The Society also has an interest in removing cost-sharing for the physical and all Medicare covered preventive services. Under MMA, the new physical will be subject to the standard co-insurance and deductible. Since studies have shown that cost-sharing has the effect of reducing the probability of patients using preventive services, we have long advocated for the elimination of cost-sharing for all cancer

[3] Institute of Medicine. Curry S., Byers T. and Hewitt M., eds. 2003. Fulfilling the Potential of Cancer Prevention and Early Detection. Washington, DC: National Academy Press, p. 429-430.

screenings. The Society is very interested in continuing to work with Congress on efforts to reduce or eliminate cost-sharing for the physical and other covered cancer prevention and early detection services.

Increase Physician Payment

As the Society has noted in our recent comments to CMS on the proposed Physician Fee Schedule, we are concerned that the payment for this benefit may not be sufficient to compensate physicians for the services provided under the examination. Under the proposed value for the new HCPCS code, G0XX2, a physician must provide several services, including an electrocardiogram, within approximately 45 minutes. Payment for this new HCPCS code will be based on CPT code 99203, *new patient, office or other outpatient visit,* and CPT code 93000, *electrocardiogram, complete.* We would like to see this physical paid using the higher level *new visit* code, CPT code 99205. We are concerned that the current payment may not adequately compensate physicians for their time and could result in shortened visits or visits that fail to include all of the appropriate education, counseling, and referrals. The Society has asked CMS to reconsider the payment for the physical and raise it to a level that will not act as a disincentive for physicians.

Broaden Tobacco Cessation Resources

The Society also has a long-standing interest in tobacco use cessation and strongly advocates for the availability of and access to both cessation counseling and appropriate drug therapies for all of the reported 70 percent of smokers who want to quit. Currently, Medicare does not cover cessation counseling nor does it cover nicotine replacement therapies (NRT). Medicare will begin to cover NRTs available by prescription only once the new prescription drug coverage goes into effect on January 1, 2006. Given the limited cessation-related resources that will be available to patients—at least initially, we have asked CMS for clarification on what physicians will be able to do for patients during the first year of the benefit and later after the prescription drug benefit goes into effect. We appreciate that the new physical presents an opportunity for the physician and patient to begin the discussion about tobacco cessation, and we will continue our work with you to secure coverage for a full cessation counseling benefit. Furthermore, the Society devotes extensive resources to tobacco cessation, including the operation of a quitline in a number of states, and would be pleased to serve as a resource to physicians seeking cessation services for their patients. We note that the report on the Medicare cessation demonstration, "Medicare Stop Smoking Project," should be released shortly, and we look forward to working with Congress and CMS to address its recommendations.

The Importance of Outreach

The Society recognizes that securing coverage for the physical is only half of the battle—we must also do our part to ensure that patients know about the new benefit and use it appropriately. Therefore, the Society is currently focused on using our organization-wide resources to get the word out to patients and physicians that this new benefit exists. We have already begun working on a variety of initiatives on our own and were also recently invited by CMS to begin an outreach partnership with them and our partners in the PHP.

The PHP's ultimate goal is to stimulate improvements in chronic disease prevention and early detection. Together, we strive to raise public awareness about healthy lifestyles and enhance the focus on prevention among health care providers. The PHP has begun a comprehensive public awareness campaign, "Everyday Choices For A Healthier Life," which includes television and radio PSAs sponsored by The Ad Council, a joint website, an 800-number and educational materials.

With respect to the physical, the Society's education efforts are beginning now so that we can reach as many of those who will become Medicare beneficiaries in the beginning phases of this new benefit as possible, but these efforts will be on-going. Some of the things the Society is already working on include:

- Beginning educating physician memberships and our staff and volunteers by sharing a fact sheet on the physical that we prepared from statutory language. The fact sheet has already been distributed at the American Society of Clinical Oncology's annual meeting and the Primary Care Advisory Meeting, and will be distributed at the American Academy of Family Practitioners annual meeting.
- Sharing Society expertise with CMS by arranging a meeting between CMS staff and our Director of Cancer Screening to discuss the implementation of the physical and to discuss the possibility of helping CMS create a checklist that physicians can use during the physical. The Society has also submitted comments to CMS on the proposed Physician Fee Schedule's implementation of the physical.

- Working to raise media attention about the physical prior to the release of the regulation and again after the proposed regulation was released. The Society will continue to do outreach with reporters as the January 1 implementation date approaches.
- Conducting on-going discussions with CMS about partnership opportunities with the Society and the PHP such as potential joint events with the CMS Administrator that publicize the physical and encourage patients to schedule the visit.

Other resources the Society plans to use to educate beneficiaries include the following:

- Using our "direct channels" such as our website, call center and the cancer survivors network
- Drafting articles on the benefit for our CA Journal and working with various other groups to publicize the physical at other professional meetings in the fall.
- Exploring other possibilities such as creating a Continuing Medical Education course on the physical and considering other ways in which we can work with the American Diabetes Association and the American Heart Association through the PHP to create joint activities.

Conclusion

The Society appreciates the leadership of this Committee in securing coverage for the "Welcome to Medicare" physical and Congress' bipartisan support for the provision. We look forward to working with you and CMS to ensure that new Medicare beneficiaries and their providers are aware of and utilize the opportunity for prevention the physical represents. On behalf of the Society, and the more than 1.3 million Americans who will be newly diagnosed with cancer this year, we thank you for your time and the opportunity to present testimony.

PREPARED STATEMENT OF ERIC J. HALL, CEO, ALZHEIMER'S FOUNDATION OF AMERICA

Chairman Bilirakis, Ranking Member Brown, and distinguished Subcommittee members: On behalf of the Alzheimer's Foundation of America (AFA), thank you for holding this important hearing on preventive benefits enacted as part of the Medicare Modernization Act of 2003 (MMA).

AFA believes the preventive benefits enacted under the MMA represent an important step forward in improving the health of our nation's Medicare beneficiaries. In particular, Mr. Chairman, we support and applaud your efforts to establish an initial preventive screening examination under Medicare.

AFA's Mission

An estimated five million Americans currently suffer from Alzheimer's disease, and the number is expected to rise to 16 million by mid-century. It is therefore critical that we all stand together for care as the incidence of this devastating disease continues to rise.

AFA was founded as a nonprofit 501(c)(3) organization to fill a gap that existed on the national front for advocacy of "care . . . in addition to cure" for individuals affected by Alzheimer's disease and related dementias. AFA and its members provide direct services to millions of Americans living with Alzheimer's disease and related disorders nationwide, as well as their caregivers and families. Our goals include improving quality of life for all those affected and raising standards for quality of care.

AFA operates a national resource and referral network with a toll-free hotline, develops and replicates cutting-edge programs, hosts educational conferences and training for caregivers and professionals, provides grants to member organizations for hands-on support services in their local areas, and advocates for funding for social services. It annually sponsors two national initiatives, National Memory Screening Day and National Commemorative Candle Lighting. AFA is also working to promote healthy aging through prevention and wellness education and to expand screening for memory impairment as a tool to facilitate early diagnosis and treatment.

The Importance of Memory Screening

Early recognition of Alzheimer's disease and related dementias is essential to maximize the therapeutic effects of available and evolving treatments, and screening for memory impairment is the only way to systematically find treatable cases. Diagnosis in the early stages of the disease is vital, providing multiple benefits to individuals with the disease, families and society. Screening can also be beneficial for individuals who do not present a diagnosis of Alzheimer's disease by allaying fears and providing an opportunity for prevention and wellness education.

Memory screening is a cost-effective, safe and simple intervention that can direct individuals to appropriate care, improve their quality of life, and provide cognitive wellness information. With no "silver bullet" for dementia in the immediate future, it is essential to fully use all preventive measures and early interventions. AFA supports a comprehensive strategy that involves both research for a cure, as well as a national system of care that includes cognitive wellness, early detection and intervention, and disability compression.

To advance that objective, AFA launched National Memory Screening Day in 2003 as a collaborative effort by organizations and health care professionals across the country. AFA initiated this effort in direct response to breakthroughs in Alzheimer's research that show the benefits of early medical treatment for individuals with Alzheimer's disease, as well as the benefits of counseling and other support services for their caregivers.

AFA's annual National Memory Screening Day underscores the importance of early diagnosis, so that individuals can obtain proper medical treatment, social services and other resources related to their condition. With no cure currently available for Alzheimer's disease, it is essential to provide individuals with these types of interventions that can improve their quality of life while suffering with the disease.

During National Memory Screening Day, healthcare professionals administer free memory screenings at hundreds of sites throughout the United States. A memory screening is used as an indicator of whether a person might benefit from more extensive testing to determine whether a memory and/or cognitive impairment may exist. While a memory screening is helpful in identifying people who can benefit from medical attention, it is not used to diagnose any illness and in no way replaces examination by a qualified physician.

Our goal is for individuals to follow up with the next steps—further medical testing and consultation with a physician, if the testing raises concerns. The latest research shows that several medications can slow the symptoms of Alzheimer's disease and that individuals begin to benefit most when they are taken in the early stages of memory disorder. This intervention may extend the time that individuals can be cared for at home, thereby dramatically reducing the costs of institutional care.

With early diagnosis, individuals and their families can also take advantage of support services, such as those offered by AFA member organizations, which can lighten the burden of the disease. According to several research studies, such care and support can reduce caregiver depression and other health problems, and delay institutionalization of their loved one—again reducing the economic burden of this disease on society.

In addition, with early diagnosis, individuals can participate in their care by letting family members and caregivers know their wishes. Thus, memory screenings are an important tool to empower people with knowledge and support. Just as importantly, the screenings should help allay fears of those who do not have a problem.

AFA holds National Memory Screening Day on the third Tuesday of November in recognition of National Alzheimer's Disease Month. Broadcast personality Leeza Gibbons is the national advocate for this event. Ms. Gibbons founded The Leeza Gibbons Memory Foundation in response to her own family's trial with Alzheimer's. She lost her grandmother to the disease, and her mother now battles with the final stages of Alzheimer's.

This year, National Memory Screening Day will be held on November 16, 2004. Individuals concerned about memory problems will be able to take advantage of free, confidential screenings at hundreds of sites across the country with the goal of early diagnosis of Alzheimer's disease or related dementias. Early diagnosis is critical, because as Ms. Gibbons has noted, "This is not a disease that will wait for you to be ready."

The Need for Federal Leadership

As promising research continues in the search for a cure, additional resources are also needed in support of efforts to delay the progression of Alzheimer's disease and related dementias. The federal government can play a critical role in that regard by providing resources for a public health campaign designed to increase awareness of the importance of memory screening and to promote screening initiatives.

Federal support is essential to expand the scope of ongoing efforts in the private sector. Working in partnership with AFA and other participating organizations, the federal government can leverage its resources cost-effectively to help overcome fear and misunderstanding about Alzheimer's disease and related dementias, to promote public awareness of the importance of memory screening, to expand options for

screening nationwide, and to direct Americans to the support services and care available in their local communities.

To that end, AFA is urging the Centers for Medicare and Medicaid Services (CMS) to provide screening for memory impairment as part of the Medicare initial preventive screening examination. CMS included a specific request for public comments on the scope of the exam in its proposed rules; therefore, AFA is recommending that CMS include screening for memory impairment within the proposed definition of a "review of the individual's functional ability, and level of safety, based on the use of an appropriate screening instrument." The proposed rules also state that review of an individual's functional ability and level of safety must address activities of daily living and home safety.

In that context, unrecognized dementia can increase the likelihood of avoidable complications such as delirium, adverse drug reactions, noncompliance, etc. These complications reduce the autonomy of affected individuals, thereby impeding their ability to perform activities of daily living and compromising their safety. In addition, about one-third of elders live by themselves, and these individuals are at greater risks for accidents, injuries, exploitation, and other adverse outcomes. Early identification allows safeguards and home assistance to assure continued maximization of home placement.

For the affected individual, identification of early stage dementia allows early aggressive use of available treatments. Early identification allows optimal therapy with available and emerging medications. Most FDA-approved medications can help slow the progression of symptoms of Alzheimer's disease and related dementias when presented in early stages of dementia.

Once dementia is identified, health care management can be adjusted to incorporate treatment strategies that accommodate a person with cognitive impairment. Issues such as patient education, self-medication, compliance, and hospital care can be adjusted to meet the needs of a mildly demented person who is at risk for common complications such as delirium and depression. Home-based support systems can be adjusted to maximize home placement for these individuals. Safeguards can be taken to prevent avoidable complications such as delirium during hospitalization.

Further, the early identification of dementia supports individual patient rights and self-determination. Mildly impaired individuals are capable of charting the future course of their care and making substantial decisions on issues like end-of-life care, resuscitation, disposition of wealth, etc. Advanced directives can be initiated that incorporate the wishes of individuals with dementia, thereby reducing the burden on the family of surrogate decision-making. Individuals with the disease can also take advantage of social services and other support that can improve quality of life. These include counseling, verbal support groups and cognitive stimulation therapies. These strategies may prolong activities of daily living, and promote a sense of dignity.

Separately, family caregivers also benefit from early identification at several levels. As noted above, early identification reduces the family burden with regard to decision-making, because families can follow the instructions of their loved ones. This process allows family caregivers to benefit early on from support groups, education and other interventions that address their unique and pressing needs. Such knowledge and support can empower them to be better caregivers and can reduce their incidence of depression and other mental and physical health problems. Intervention can also help on an economic front: lightening the burden on primary caregivers, who are also in the workforce, could help reduce employee absenteeism and lost productivity.

Finally, screening can be beneficial for those individuals who do not present a diagnosis of Alzheimer's disease. These negative results can allay fears and provide reassurance. Just as importantly, physicians can take this opportunity to present individuals with prevention and wellness education—a strategy that promotes successful aging.

We would note that use of available screening instruments to identify memory impairment during the Medicare initial preventive physical examination is consistent with current clinical practice guidelines. Individuals with mild cognitive impairment are at higher risk for subsequent development of Alzheimer's disease and related dementias. General cognitive screening instruments are available and are useful in detecting dementia in patient populations with a higher incidence of cognitive impairment (e.g., due to age or memory dysfunction). Attached for Subcommittee Members' reference is a summary of the relevant American Academy of Neurology practice guidelines for physicians.

Inclusion of screening for memory impairment is also consistent with the recent CMS National Coverage Decision expanding Medicare coverage of Positron Emission

Tomography (PET) for beneficiaries who meet certain diagnostic criteria for Alzheimer's disease and fronto-temporal dementia.

AFA believes PET and other neuroimaging devices will be a valuable tool in predicting disease and in steering those with a diagnosis of Alzheimer's or related illnesses to the appropriate clinical and social service resources. Expanded reimbursement for PET studies will drive early intervention for the increasing—and alarming—number of Americans with Alzheimer's disease. Utilization of this technology will become even more critical in the future, as the number of Americans with dementia is projected to triple by mid-century.

Conclusion

Expanded screening to facilitate the early identification of memory impairment will produce tangible benefits to society by protecting individuals, improving quality of life, and reducing the costs of health care. Enhancing compliance and protecting individuals with dementia also produces tangible financial benefits to the health care system. Intervention can enable individuals to remain independent longer and can reduce the costs of insurance, absenteeism and lost productivity at work for primary caregivers—currently estimated at $60 billion annually.

AFA commends the Subcommittee's leadership in striving to improve preventive care for our nation's Medicare beneficiaries. We would likewise welcome the opportunity to work collaboratively to improve the quality of life for Alzheimer's patients, their families and caregivers. Please feel free to contact me at 866-232-8484 or Todd Tuten at 202-457-5215 if you have questions or would like additional information.

Thank you for the opportunity to share our views.

Sincerely,

ERIC J. HALL
Chief Executive Officer

ACOG Testimony to the House Committee on Energy and Commerce
Subcommittee on Health

Improving Women's Health: Understanding Depression After Pregnancy

September 29, 2004

The American College of Obstetricians and Gynecologists (ACOG), on behalf of its 46,000 partners in women's health care, is pleased to offer this testimony to the House Committee on Energy and Commerce, Subcommittee on Health. We thank Chairman Bilirakis, Ranking Member Brown and the entire Subcommittee for their leadership to address the serious problem of depression after pregnancy.

ACOG Fellows care for and treat women at all stages of their lives. Following a pregnancy, women have unique physical and mental needs. Although having a baby is exciting and joyous for many women, some mothers may experience sadness, fear or anger, commonly referred to as the baby blues. But ten percent of new mothers suffer from post partum depression, a more serious disorder that requires counseling and treatment. Obstetrician-gynecologists screen women for depression before, during and after pregnancy.

Depression After Pregnancy

Seventy to eighty percent of women have baby blues after childbirth. About 2-3 days after giving birth they may feel depressed, anxious and upset and may cry for no reason, or question whether they can handle caring for a baby. These feelings can last from a few hours to a week and do not require treatment.

Post partum depression is a more intense feeling of sadness, and is likely to result from physical, mental and lifestyle changes. A woman who has had psychiatric illness before the pregnancy, lacks support from a loved one, or is experiencing stress in her life, is more likely to suffer from depression after pregnancy. The levels of the hormones estrogen and progesterone, or hormones created by the thyroid, may rapidly decrease after childbirth, and this change can also result in depression. Every woman has a different biological makeup; therefore these hormonal changes affect each woman differently.

After delivery it can take weeks for a woman to regain her energy, especially women who have cesarean deliveries. The pressures of new motherhood and attending to visitors may make it more difficult for women to get adequate sleep. Fatigue and lack of sleep can also help trigger depression.

Emotionally, women may have doubt, or an inadequate amount of time to prepare for a new child in her life, and may also feel a lack of freedom, identity, and feelings of physical unattractiveness. Support from others is key during the post partum period, and new mothers need comfort and assistance with childcare and daily chores.

ACOG's Involvement

Psychosocial issues greatly impact the health and well being of women, and ACOG has been a leader in working with issues of depression for over a decade. Ob-gyns screen for depression before, during and after pregnancy, and include this information in their patient's medical records. Additionally, through a federal cooperative agreement with the Maternal Child Health Bureau of the Health Resources and Services Administration, ACOG manages the Provider's Partnership, a series of state-level projects that bring health care providers together to address key women's health issues, including perinatal depression.

ACOG recognizes that identifying women early in the pregnancy who have a history of depression or postpartum depression, or who are currently depressed, will help prevent cases or lessen the severity of postpartum depression after delivery. Recognizing the frequency of postpartum depression and the unique opportunity that ob-gyns have to screen for this, ACOG now includes screening on its antepartum record, used by ob-gyns across the country as a prenatal patient record, and its postpartum record, which is widely used by hospitals before discharging women after delivery. ACOG also includes a Psychosocial Screening questionnaire on its Obstetric Medical History, which the new prenatal patient fills out.

ACOG jointly publishes a book called *Guidelines for Perinatal Care* 5th edition with the American Academy of Pediatrics that addresses emotional lability in the postpartum period. These Guidelines are widely used not only by ob-gyns but also by other obstetric providers and nurses. Ob-gyns can intervene if this emotional lability persists or develops into clinically significant depression, and review the emotional status of a woman whose pregnancy had an abnormal outcome.

Ob-gyns can and do play a critical role in addressing these issues within their current practices, however because of the complexity of psychosocial issues and the importance of promptly linking at-risk women with appropriate services, responsibility for full psychosocial assessment and treatment cannot fall solely to ob-gyns. By linking women's health care providers, public health leadership, and community programs, the Provider's Partnership allows for integration of medical care with psychosocial services. Such partnerships enhance service integration, minimize demands on individual providers, and facilitate movement between providers and agencies with multiple disciplines and services joining to create comprehensive care. This initiative has resulted not only in innovative programs, but also enduring collaborations. The Partnership provides resource guides for providers on drug prescriptions, develops patient brochures, and implements provider training.

In addition, ob-gyns support National Depression Screening Day. Every October, ACOG members join other primary care providers to use a depression-screening questionnaire and patient education materials to screen and educate their patients on depression. ACOG published a Clinical Update on depression that addresses postpartum depression and includes a sample questionnaire for physicians to use with their pregnant patients. ACOG also produces patient books and pamphlets for pregnant women that address postpartum depression to further educate pregnant women.

Thank you again, Mr. Chairman, for your leadership in addressing this issue. We urge Congress and the Administration to continue support of post partum depression research at the National Institutes of Health, and outreach programs at the Health Resources and Services Administration. In particular, we urge continued support for the Provider's Partnership program, which is making great strides to identify, screen and treat women affected by post partum depression. ACOG looks forward to working with you and the appropriate agencies to expand research, screening and counseling, so we can successfully treat women who suffer from post partum depression.

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